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ABSTRACT

This staff development module is part of one of three groups of career guidance modules developed, field-tested, and revised by a six-state consortium coordinated by the American Institutes for Research. This module, designed for helping professionals who work with older adults, attempts to help participants: (1) examine personal biases about older adults; (2) understand critical issues facing older adults; (3) identify strengths and weaknesses in listening and attending behaviors; and (4) apply problem solving strategies in helping others. The module format consists of an overview, goals, objectives, outline, time schedule, glossary, readings, skill development activities, and bibliography. A Coordinator's Guide is also included with detailed instructions for presenting the module in a workshop setting as well as the facilitator's roles and functions, and the criteria used in assessing the participants' achievement of module objectives. (Author/HLM)

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COUNSELING NEEDS OF THE OLDER ADULT

MODULE 44

Patricia Cook and Ellen Stewart

CG 014220

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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INTRODUCTION

MODULE GOAL AND OBJECTIVES

This module emphasizes entry level knowledge and skills and is directed toward beginning counselors, peer counselors, paraprofessional helpers and volunteer workers who are interested in utilizing helping strategies with older adults. The module focuses on aiding participants to identify stereotypes and personal biases they might have in relation to the older adult; to understand some critical issues facing the older adult; to identify strengths and weaknesses in your listening and attending behavior; and to apply a problem solving strategy in helping others.

On completion of this module, you will be able to:

Objective 1. Identify and described in writing: (1) at least one negative bias, stereotype, or attitude about the older adult which you personally hold at this time and the possible effects of that bias on your ability to help older adult clients; and (2) at least one positive attitude you have regarding the older adult and the possible client benefits to be derived from it.

Objective 2. Describe examples of older adults' positive and negative accommodation to change in life role status and state examples of factors that explain each type of accommodation.

Objective 3. Identify strengths and/or weaknesses in your listening and attending skills.

Objective 4. Apply a problem solving strategy to help older adults solve problems.

GLOSSARY

Counselor - This term is sometimes used to refer to "guidance personnel." The intent should generally be all those working in any way in guidance including teachers, administrators, parents, and so on. The broader term is generally preferable.

Older adult - "Older" adults for the purpose of this module are people 65 years or older.

Paraprofessional - An aide to a professional who has been given special training in order to assist with activities previously reserved for the professional. Paraprofessionals do not have the level of education or the credentials of the professional. Activities performed by the paraprofessional are at the lower order of competence of the professional and are carried out under supervision of a professional.

INTRODUCTORY ACTIVITY

What is it going to be like for you when you reach 65 or 70? Or if you are already 65 or 70, what's it going to be like ten or 15 years from now?

Write down an age in terms of the sentences above. Try to imagine what your life will be like when you reach that age. Think of all the older adults you know now. How will your life in the age you choose be compared with theirs?

In the spaces provided below write down one adjective that you feel would best describe your situation at the age assigned to you. List one adjective under each category.

Physical/Mental Health

Family Relationships

Interests and Activities

Finances

Personality Traits

FACTS ON AGING

A SHORT QUIZ

Reprinted by permission of the publisher, *The Gerontologist*. Facts on Aging: A Short Quiz. Erdman Palmore. *The Gerontologist*, Vol. 17, No. 4, 1977. pp. 315-316.

Circle "T" for True or "F" for False.

T F 1. The majority of old people (past age 65) are senile (i.e. defective memory, disoriented, or demented).

T F 2. All five senses tend to decline in old age.

T F 3. Most old people have no interest in, or capacity for, sexual relations.

T F 4. Lung capacity tends to decline in old age.

T F 5. The majority of old people feel miserable most of the time.

T F 6. Physical strength tends to decline in old age.

T F 7. At least one-tenth of the aged are living in long-stay institutions (i.e. nursing homes, mental hospitals, homes for the aged, etc.).

T F 8. Aged drivers have fewer accidents per person than drivers under age 65.

T F 9. Most older workers cannot work as effectively as younger workers.

T F 10. About 80% of the aged are healthy enough to carry out their normal activities.

T F 11. Most old people are set in their ways and unable to change.

T F 12. Old people usually take longer to learn something new.

T F 13. It is almost impossible for most old people to learn new things.

T F 14. The reaction time of most old people tends to be slower than reaction time of younger people.

T F 15. In general, most old people are pretty much alike.

T F 16. The majority of old poeple are seldom bored.

T F 17. The majority of old people are socially isolated and lonely.

T F 18. Older workers have fewer accidents than younger workers.

T F 19. Over 15% of the U.S. population are now age 65 or over.

T F 20. Most medical practitioners tend to give low priority to the aged.

T F 21. The majority of older poeple have incomes below the poverty level (as defined by the Federal Government).

T F 22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).

T F 23. Older people tend to become more religious as they age.

T F 24. The majority of old people are seldom irritated or angry.

T F 25. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.

SECTION ONE

THE OLDER ADULT--BIASES AND STEREOTYPES

(OBJECTIVE ONE)

Let's take a closer look at some of the negative biases and stereotypes about the elderly. Read over the following paragraph. In it, Robert Butler (1975: 6-7) has embodied a multitude of the myths that surround old age:

> An older person thinks and moves slowly. He does not think as he used to or as creatively. He is bound to himself and to his past and can no longer change or grow. He can learn neither well nor swiftly and, even if he could, he would not wish to. Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas. Not only can he not move forward, he often moves backward. He enters a second childhood, caught up in increasing egocentricity and demanding more from his environment than he is willing to give to it. Sometimes he becomes an intensification of himself, a caricature of a lifelong personality. He becomes irritable and cantankerous, yet shallow and enfeebled. He lives in the past; he is behind the times. He is aimless and wandering of mind, reminiscing and garrulous. Indeed, he is a study in decline, the picture of mental and physical failure. He has lost and cannot replace friends, spouse, job, status, power, influence, income. He is often stricken by diseases which, in turn, restrict his movement, his enjoyment of food, the pleasures of well-being. He has lost his desire and capacity for sex. His body shrinks, and so too does the flow of blood to his brain. His mind does not utilize oxygen and sugar at the same rate as formerly. Feeble, uninteresting, he awaits death, a burden to society, to his family, and to himself.

We are going to break down Butler's paragraph to conform to the categories used in the Introductory Activity.

<u>Physical/Mental Health</u>

> "He is often stricken by diseases which, in turn, restrict his movement, his enjoyment of food, the pleasures of well-being. He has lost his desire and capacity for sex. His body shrinks, and so too does the flow of blood to his brain. His mind does not utilize oxygen and sugar at the same rate as formerly."

"An older person thinks and moves slowly. He does not think as he used to, or as creatively... He can learn neither well nor swiftly and, even if he could, he would not wish to... He is aimless and wandering of mind... Indeed,...the picture of mental and physical failure."

Finances

"...demanding more from society than he is willing to give to it... He has lost and cannot replace...job, status, power, influence, income."

Relationships with Family and Friends

"He has lost and cannot replace friends, spouse... [he is] a burden to society, to his family, and to himself."

Interests and Activities

"He is bound to himself and to his past and can no longer change or grow... Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas.

Personality Traits

"He becomes irritable and cantankerous, yet shallow and enfeebled ...reminiscing and garrulous."

Generalizations about a particular group of people are not only common, but sometimes helpful and necessary. For example social scientists often group people for studies that result in the development of better services or provide information on living patterns, educational needs, or cultural patterns. The harm comes when we apply these generalizations so stiffly that we fail to take into account individual differences, and the individual is deprived of her/his rights, services, or in some cases, self-respect. Generalizations then become stereotypes.

Personal biases, like stereotypes, can influence the way we deal with people. While there can be a positive as well as a negative side

to biases (personal preferences, partialities, or inclinations), the degree to which we let them influence our dealings with others may affect the relationship we establish or the other person's ability to sort out solutions to his/her own problems.

After discussion of this part, you will be involved in reading one of the following sections. The Coordinator will give specific directions.

Section 1: Physical Health

Section 1 adapted from: *Working with Older People: A Guide to Practice.* Volume II, Biological, Psychological and Sociological Aspects of Aging. Public Health Service, U.S. Department of Health, Education, and Welfare (1970).

Increasing Elderly Population

Half of all people now 65 and older are about 73 or older; 6 percent are 85 or older--more than 1 million persons. In the years ahead, the increase will be particularly great at the oldest ages. With the population 65 and older projected to rise 50 percent between 1960-85, the population 85 and older may double.

Need for Increased Preventative and Therapeutic Services

The steady increase in the numbers of old and "older" old persons in the population is particularly significant in view of the fact that chronic disease, long-term illness, and disability comprise the bulk of the health problems of adults in their later maturity. Consequently the increase in the need for preventive and therapeutic services for this age group will be greater than the increase in numbers suggests. Physical diseases which disable or kill the greatest number of the aged are cardiovascular-renal diseases, cancer, arthritis, tuberculosis, diabetes, and glaucoma.

According to the National Health Survey, during the year ranging from July 1966 to June 1967, about 7 out of 10 persons between the ages of 45 to 64 (71.6 percent) had one or more chronic conditions, as compared with more than 5 out of 6 persons aged 65 and older (86 percent). The findings further reveal that the extent and intensity of physical disabilities associated with chronic disease increase sharply with age.

Variations among the age groups with regard to the mobility limitations provide a revealing yardstick. A person has a mobility limitation when he has difficulty getting around alone, when he needs special aid or help from another person in carrying out the activities of daily living, or when he is confined to the house because of a physical condition. Of the total population, fewer than 1 out of 100 of those under 45 are affected in this way, compared to 1 out of 20 of those 34-64, and almost 1 out of 5 of those 65 and older.

Multiplicity of Ailments

It is important, too, to keep in mind the fact that the aged more frequently suffer from a multiplicity of ailments.

This is the Nation's chronic disease picture by category:

--14.6 million adults have definite heart disease, and an additional 13 million have suspected heart disease;

--2 million are known to be diabetic;

--13 million report some form of arthritis;

--1.2 million have activity-limiting visual impairment;

--upwards of 500,000 new cancer cases are diagnosed each year;

--heart disease, cancer, and stroke account for more than 70 percent of all deaths in this country.

Illness and Poverty

It is an undisputed fact that medical needs and the cost of meeting these needs rise with declining health, and that the impact of chronic diseases is greatest among the elderly. Of the total $41.5 billion health care bill for the total population in the fiscal year 1967, more than one-fifth ($9.2 billion) was used by, or in behalf of the aged who comprise approximately one-tenth of the total population. The rise in cases is only partly met by Medicare, which covered 35 percent of the health costs of the aged in 1967. Of expenditures for hospital care, 57 percent was through the Medicare program. For many of the elderly, illness serves as a major cause of poverty by reducing their incomes; conversely, poverty can be a major contributory cause of illness when it serves as a barrier to receiving adequate medical care.

The elderly use more physician services than do young persons. The U.S. average for persons below age 45 is 4.0 visits per year, for those 45 to 64 it is 4.7 visits per year, and for those 65 and older it is 6.0 visits per year.

The elderly have more admissions to hospitals, and stay longer. For example, persons 65 and older account for 14.5 percent of hospitalizations, even though this age group comprises 9.3 percent of the civilian non-institutional population. The rate of hospitalization among the elderly has been increasing. The length of stay for the elderly is 13.8 days (as against 6.5 days for those under 45). Moreover, the elderly are prime users of nursing homes and other long-term care facilities. As home-health agencies develop, the elderly undoubtedly will be prime users of these, too.

The elderly use more prescribed drugs. The per capital expenditure for prescription drugs for the elderly was more than 3 times greater than

than for those with no disabilities.

Gerontology, Health, and Aging

Gerontology studies the biological, behavioral, and social manifestations of aging. The gerontologist tries to determine what happens to the organism and groups of organisms as time passes. From the practitioner's point of view, the biggest questions for gerontology are: "Is there a mechanism of aging, as distinct from disease? Can the effects be prevented, modified, and repaired?"

Today, there are no definite answers. There may be one or more mechanisms fundamental to the manifestations of aging, including susceptibility to chronic disease. Gerontologists admit there is a big difference between "changes with age" and "changes due to an aging process." One biologist says that there is no single process which is known to determine aging.

Aging has been thought of as vulnerability to stresses. These may be disease, accident, or psychosocial events, such as widowhood, economic deprivation, and loss of social status. It may be that our oldest people are extraordinary survivors because of their psychobiological equipment, not only genetic endowment but also acquired abilities to cope with environmental stress.

Aging probably has a basic relationship to chronic disease, which is a growing challenge to research and therapy. Since 1940, death rates from heart disease and cancer have each increased by one-fourth. The U.S. rate for heart disease is among the world's highest. Among males in the productive ages of 40 to 54, mortality rates are substantially higher in this country than in other industrial nations and almost twice the rate of that in Sweden.

While chronic diseases have grown, death rates from infectious diseases have declined. Between 1910 and 1940 the death rate from influenza and pneumonia was cut 55 percent; it has since been halved again. But the rate of decline in these and other infectious diseases has slowed or stopped. Possibly, antimicrobial therapy has approached its maximal contribution to mortality reduction for the U.S. population in general, and for the aged, particularly, the limit of antibiotic protection apparently is being reached. It is likely that antibiotics cannot provide any further extension of protection for the highly vulnerable aged person.

Thus, despite antimicrobial therapy and other contributions to health, a basic death pattern still prevails. The Gompertz plot, a mortality equation formulated in the early Nineteenth Century, states that the likelihood of death doubles every eight years of adult life. This observation is considered one of the best indications of an underlying aging process, as distinct from disease.

Section 2: Mental Health

Section 2 adapted from: *Why Survive? Being Old in America.* Robert N. Butler (1975). Chapter 8: "They Are Only Senile," pp. 225-231. By permission of Harper and Row, Publishers.

Emotional Health

What is good mental health in old age? It means the capacity to thrive rather than simply survive. All of us meet older persons who are described as "full of life," "young for their years," "bright-eyed" and "zesty." Some older people appear serene and contented yet actively involved in life. Others delight in struggle or fighting for a cause. One sees in them the ongoing capacity for creativity, curiosity and surprise as well as a sense of consummation or fulfillment in life. Some may actively seek change and new knowledge while others concentrate on consolidating what they have built up over a lifetime. There are many ways to be emotionally healthy in old age, but several common themes emerge: the desire to be an active participant, to make one's own decisions, and to share mutual love and respect with others. Healthy older people experience many of the same feelings and responses as people of all ages, yet old age has its own unique flavor. The special qualities of late life come from having lived nearly an entire life span with all that this entails, and from facing the issues inherent in old age--time, aging, and eventual death. Ultimately this means facing the meaning of one's own life.

Old age has the potential for being an immensely interesting and emotionally satisfying period of life. But this potential is endangered by many forces. Change and loss are predominant themes. Loss of physical health and the death of important persons--spouses, close friends, colleagues, relatives--are occurrences in late life which tend to place enormous stress on human emotions. Crises of all kinds must be met, sometimes one after another, sometimes simultaneously--retirement, widowhood, major and minor illnesses, changes in bodily appearance, sensory losses, a feeling of decreasing social status, and for many elderly, a drastically lowered standard of living. There is much energy expended as the old go through the process of mourning for their losses, resolving grief, adjusting to the changes involved and recovering from the stresses. Multiple crises can leave people drain emotionally and weakened physically.

The age-related life crises, together with the stresses of daily living, produce a range of emotional problems from mild to severe, depending on the individual's personality and earlier life experiences, physical health and social and family supports. Finances, shelter, medical care and social roles are all intricately connected with

emotional responses and capacities. Feelings of grief, guilt, loneliness, depression, despair, anxiety, helplessness, and rage are common and should not in themselves be considered mental disorders. If they remain unresolved, causing problems in necessary functioning or a great deal of emotional pain, outside assistance is advisable.

Emotional Problems or Mental Illness?

The point at which problems become severe enough to be called mental illnesses or disorders is difficult to establish. Serious problems in functioning, extraordinary emotional distress, and various observable symptoms of emotional and/or mental impairment are criteria by which behavior can begin to be evaluated. The mental disorders of old age are of two kinds: the organic disorders which have a physical cause, and the functional disorders which appear to be related to one's personality and life experiences. Organic disorders, also called organic brain syndromes, can be reversible or chronic. The reversible brain syndromes can often be successfully treated. Chronic brain syndromes, on the other hand, are the result of permanent damage to the brain, as in cerebral arteriosclerosis and senile brain disease. They can be treated symptomatically but not reversed. Functional disorders refer to psychotic disorders, neuroses of various kinds, personality disorders and psychophysiological disorders...

All too often, mentally confused older people are sent home untreated by doctors and hospitals when they are suffering from reversible confusional states--a surprising number of which are due to malnutrition, anemia, alcohol and unrecognized physical ailments including congestive heart failure, infections and even fecal impaction. For example, doctors have created acute brain disorders through the use of tranquilizers. Many workers, such as Cosin in Britain have demonstrated the treatability of confusional states in the elderly.

The extent of mental disorders of all types can only be guessed at since so many of the elderly exist outside the purview of medical, psychiatric and social programs. A million persons over 65 are in institutions, primarily nursing homes, and well over 50 percent of these have evidence of some psychiatric symptomology and mental impairment. About two million people living in the community have serious chronic disorders. A minority of these are primarily mental disorders, but while the majority are physically based, there are often associated emotional reactions requiring attention. Added to this are the elderly patients in mental hospitals (138,000 in 1968). The poverty conditions under which seven million elderly live are known to contribute to mental breakdown--among them malnutrition, stress and victimization through crime. And last, one must consider the emotional toll suffered as a result of lowered social status and loss of social roles.

Until recent pressures against admission, Americans 65 and older

accounted for about 25 percent of the annual state-mental-hospital admissions. One study by the National Institute of Mental Health (reported by the World Health Organization in 1959), shows the following occurrence of new cases of psychopathology of all types:

2.3 cases per 100,000 population	Under age 15
76.3 cases per 100,000 population	25-34
93.0 cases per 100,000 population	35-54
236.1 cases per 100,000 population	Over age 65

Clearly those over age 65 are the most susceptible to mental illness.

Suicides, too, increase with age and it is surprising to learn that the rate of suicide is highest in elderly white men, probably the result of several causes: loss of status (in the largely white male-dominated society), desire to protect finances for a surviving wife, and a decision to avoid otherwise unavoidable physical helplessness and obdurate pain. For nonwhite women and men and for white women the curve of suicide is bell-shaped, with the greatest peak during the earlier adult and middle years. Twenty-five percent of all known suicides take place in the over-65 population (that is, among 10 percent of the nation's population). More than that probably occur since families out of shame or guilt are frequently unwilling to report suicides.

When signs of emotional problems and mental disorders emerge in old age, immediate diagnosis and treatment are crucial, particularly in the case of the reversible brain disorders... Prompt care can be preventive in avoiding full-blown functional disorders if, for example, depression or anxiety can be alleviated. Older persons ordinarily face more stresses than the young and, given their declining reserves of strength, they may require swift attention in order to avoid being overwhelmed emotionally. Ideally, treatment should be a collaborative effort among the patient, his family if he has one, and mental-health personnel, with the patient or a family member making the initial request for services....

Providing Mental Health Services for the Elderly

Contrary to popular professional opinion, older persons can make effective use of the whole gamut of mental-health services, including psychotherapy, psychoanalysis, group psychotherapy, drug therapy, occupational, physical and recreational therapies, behavioral modification therapies, family and marital counseling, and last, but by all means not least, sex counseling and therapy. Because of the mental-health profession's disinterest in and prejudices against the old, and the overt and covert forms of discrimination on the part of agencies and institutions, most elderly persons never have a chance to obtain mental-health services. As one illustration, nursing homes seldom provide any form

of psychiatric care, in spite of the fact that over 50 percent of their residents have been found to have psychiatric problems of sufficient magnitude to warrant professional attention.... Other factors enter into the failure to obtain care: lack of the information necessary to recognize important symptoms on the part of the patients and their families; shame or fear of mental illness; lack of knowledge regarding services; guilt in family members, who think they should be able to handle things; improper diagnoses by medical and mental-health personnel; and lack of services designed especially for the old....

One important way in which mental-health professionals can become more effective is to become aware of their own feelings toward the elderly. For example, I have found it extraordinary in my consultative experience with a range of mental-health specialists, from psychiatrists to social workers, that they are so often impatient and irritable with their older patients for not responding swiftly to their ministrations. It would not occur to them to push for such rapid improvement in younger patients. In part, they fear the implacable clock: there will not be time enough in which to work. In part, they reflect the notion that old people cannot change. Ironically, part of the reason old people are eminently capable of change is that they stand so near to death. They have things to accomplish before it is too late....

One function of mental-health specialists which has direct application to work with older people is cultivation of the art of listening. The so-called garrulousness of old people and their wish to hold on so tenaciously to someone's attention is a social sympton related to their loneliness. Patience, listening and simply spending meaningful time with them are of great therapeutic value. Older people use reminiscence to review their lives and resolve problems, much as does classical psychoanalysis.

One of the great losses of old age is the loss of choice. Needs, interests and desires differ greatly. Choice, exercised as freely as possible, supports self-respect; when denied, it promotes helplessness. Symptoms such as anxiety, depression, dependency and anger rapidly develop when a person--of any age--has few options. Therapists should encourage a great variety of alternatives both in the emotional lives of old people and through changes in the social environment which touches their daily existence.

Irreversibility of emotional and mental disorders must never be casually assumed. Many conditions are subject to amelioration. Even people affected by the chronic brain syndromes or chronic physical illnesses have anxiety and depressive symptoms which are responsive to treatment. Depressive, paranoid and behavioral reactions present in the clinical course of organic brain damage can be helped. Depression may be masked as an organic state, showing itself as physical symptoms and, if recognized, it can be treated. At the very least, intimate human

human responses are nearly always helpful.

Research evidence supports clinical impressions that older persons benefit from mental-health care. Studies in *private* mental hospitals show that as many as 75 percent of patients over 65 are returned improved to their own homes within two months. Outpatient work in clinics and private offices also reveals capacities for change and recovery. Even severely brain-damaged patients respond in a prosthetic (artificial) milieu with well-planned programs for orientation, activities, socialization. Clearly, if there is a combination of resources and genuinely motivated interest on the part of professionals, older people, like patients of other age groups, respond to treatment.

Section 3: Finances

Section 3 adapted from: *Why Survive? Being Old in America.* Robert N. Butler (1975). Chapter 2: "How to Grow Old and Poor in an Affluent Society," pp. 24-29.
By permission of Harper and Row, Publishers.

The Total Income Picture

To understand the poverty of older Americans in an affluent society we need to see how the old currently are supported and the difficulties they experience. Those 65 and older as a group receive their aggregate income as follows:

TABLE 1

Percent of Income	*Income Source*
46	Retirement benefits (Social Security, 34%; public pensions, 7%; private pensions, 5%)
29	Earnings from employment
15	Income from assets
4	Public assistance
3	Veterans' benefits
3	Other (contributions from family, etc.)

The Old Grow Poor

Two crucial and distressing facts about poverty and old age are clear. First, although the numbers of those in poverty in other age groups are said to be decreasing, there has been an increase in both the number and proportion of aged poor. The U.S. Senate Special Committee on Aging, using the conservative government-established poverty threshold, reported that in 1969 there were approximately 4.8 million people aged 65 and older who were living in poverty, almost 200,000 more than in 1968. In this same period, said the committee, poverty declined by 1.2 million for all other age groups.

Second, the elderly are the fastest-growing poverty group. This is new poverty, not simply poverty transmitted from generation to

generation within the same family. Independently of previous means and previous socio-economic status, one may be thrown into poverty for the first time in old age. Catastrophic diseases, or the sheer cutback of income in retirement, may create instant poverty where none previously existed.

In fact, *many--I think most--elderly poor have become poor after becoming old.* What does it mean in the lives of retired persons to receive a total pension income from both public and private sources of one-quarter to one-half or less of their average preretirement earnings?

What Is Poverty?

How does one arrive at a realistic idea of what constitutes poverty in old age? The official government estimate of poverty, that is, the amount of income necessary to meet essential needs, is based on the Department of Agriculture's Economy Food Plan for emergency use, designed to keep a healthy person alive and functioning reasonably for thirty days. Since the average family spends approximately one-third of its income on food, government economists multiplied this amount for food by three to obtain the total minimal budget that one could possibly live on; those with less are considered poor. In 1973, for an individual this was an income of $2,100 a year or less. The 1973 weighted average for a two-person older family was $2,640.

What if we take a less biological view of poverty and consider more than brute survival by examining the lot of the aged in terms of America's standard of living? The Retired Couple's Budgets of the Department of Labor estimate what a "modest but adequate" standard of living would cost, rather than an emergency budget. These budgets are detailed listings of items and quantities to meet the normal needs of an urban retired couple as judged adequate by the staff of the Bureau of Labor Statistics (BLS), which intermittently revises them.

The "experts"--economists, statisticians and social-science analysts--develop these hypothetical budgets for a hypothetical standard of living, assuming an existing inventory of clothes, furniture, appliances and so on. The retired couple is defined as a husband, age 60 or over, and his wife, who are self-supporting, living independently in their home, in reasonably good health and able to take care of themselves. More recently the Bureau of Labor Statistics has designed two additional Retired Couple Budgets, one at a somewhat lower standard of living and the other at a higher standard. "All three budgets provide for the maintenance of health and allow normal participation in community life, taking into account social and conventional as well as physiolgoical needs." So say the government experts--but is this the case?

Do the Old Need Less?

The total Intermediate Budget for the Retired Couple, calculated in 1971, was $4,776. Let's look at what that detailed budget allows. The staff concluded that $24 per week was adequate for groceries. (An elderly couple was allotted a little over $3 per meal plus tip in a restaurant once every week.) Housing averaged $139 per month, including household repairs and furnishings. For example, 1 percent of a sofa could be purchased every year. In the way of clothes, every year 7 percent of a topcoat was allowed for a man, one and one-fourth of a street dress for a woman, one house dress, two-thirds of a bra, etc. The husband was allowed 15.3 haircuts a year and his wife 1.7. For each person, one-fifth of an eye examination for glasses was allowed and one-half pair of glasses. Needless to say, it is not possible to live statistically.

America advertises and fantasizes old age as a period of leisure, travels and hobbies, but the recreation allotment in 1971 was $91 a year for both the husband and wife. No allowance was made for visits with children, travel away from home or vacation costs. The retired couple was alloted $5.30 a year to provide for a pet animal, which is for many people their major solace in loneliness, and often an aid to safety as well. Traditional American virtues have emphasized providence, but no money was allotted for savings.

The Retired Couple's Budgets in themselves tell us something about popular conceptions about the old "needing less." The Bureau of Labor Statistics has developed a whole set of budgets to describe a modest but adequate income for different family compositions. To compare the itemized accounts of these budgets for retired and younger couples with those for the four-person family is informative. One might expect housing, transportation and certain other costs to be greater for the larger younger family and some personal-care costs to be higher for the older family, which is, indeed, reflected in the budgets. But the reasoning behind the appreciably smaller clothes allowances for the adults in the older family or for home furnishings or gifts and contributions is less understandable. In the intermediate budget, for example, the retired man was allowed $94 for clothing, and the younger wife $211. Should we automatically assume that retired men and women are going to be leading drab and inactive lives. The older family was allotted $231 for gifts and contributions, the younger family $270. Yet the older couple might well have children and grandchildren to make gifts to, as well as churches and special causes to which to contribute.

Retirement budgets are calculated on the assumption that the older couple have already accumulated much of what they will need for the rest of their lives. This is asking a lot of the healthy, potentially active older couple who may have twenty or more years ahead of them--if not the hundred years it would take to save the 1 percent a year allotment toward a new sofa! Are the elderly expected to keep their

appliances and furniture in better shape than the rest of the population in our economy of planned obsolescence? Are they espected to care less for the satisfaction of wearing something new on those special occasions when they go out? What do we know about the spending patterns of older people?

In studies of consumer expenditures high-income families--whether younger or older--tend to show similar expenditure patterns. In other words, if older couples have the money, they are as interested in recreation, clothes and a pleasant home environment as anyone of any age. *The reason old people spend less is that they have less to spend.*

To put these two government estimates--the poverty line and the modest but adequate budgets--into perspective, let us note that economist Leon Keyserling considers those who are above the poverty line but below the Bureau of Labor Statistics budget to be living "in deprivation." In terms of elderly couples and individuals the following are the poverty "definitions" and "guidelines" available at the time of the White House Conference on Aging:

TABLE 2

Organizations Which Have Defined Poverty	Point Below Which Poverty Occurs	
	Couple	Individual
Official poverty level, 1970	$2,328	$1,852
Retired Couple's Budget (Bureau of Labor Statistics, 1971)		
Intermediate Budget "Modest but Adequate"	4,776	2,627*
Higher Budget	7,443	4,094
National Welfare Rights Organization, 1971	**	2,250
Chairman, National Caucus on Black Aged, 1971	9,000	6,000

*Estimated at 55 percent of couple.
**No "guideline" available.

Hobart Jackson, chairman of the National Caucus on the Black Aged, affirms that an adequate income is the chief need of the elderly. He sets a minimum floor of $6,000 for a single old person and $9,000 for an aging couple. Jackson's figures are much more realistic than the official guidelines. They begin to approximate the median income of Americans regardless of age. The National Council of Senior Citizens, however, only supports the recommendation of the 1971 White House

Conference on Aging for approximately $4,500 a year per couple, which was less than the 1970 Retired Couple's Intermediate Budget. Official 1967 analyses of the Retired Couple's Budgets against actual income levels, completed by the Bureau of Labor Statistics, found that 56 percent of all older couples had less income than even this "modest but adequate" budget!

Estimates of government agencies and private organizations--other than the National Caucus--run low because of conceptions of "political realities." In other words, requests and estimates are determined by what politicians feel have a chance of being approved by Congress, or the President, or an appropriate state official, rather than by what is needed. Government agencies also feel pressures to minimize the estimate of need. Increasingly, mild reform proposals become no more than mere ritual, a tinkering with the lives of the old.

What would it cost to provide a better standard of living? The National Welfare Rights Organization estimated in 1971 that to bring all Americans up to their minimal budget estimates ($6,500 for a family of four, $2,500 for a single person) would cost between $30 and $50 billion. Other agencies and organizations have offered similar estimates. To support all age groups decently will cost a lot of money; it cannot be done cheaply. As a people we either want to direct our resources in this direction or we do not.

Section 4: Overview - Family, Finances, Health

Section 4 reprinted by permission of *Time: The Weekly News Magazine.* "New Outlook for the Elderly," June 2, 1975, pp. 44-51.

Throughout history the aged have occupied a precarious position in society. Some primitive peoples like the Eskimos and other nomads respected the elderly but left them to die when they could no longer care for themselves. Natives of some South Seas islands paddled away from their families--to death--when age overtook them. Nor is the idea of abandoning the elderly unique to primitive societies. Marya Mannes' 1968 novel *They* postulated a world in which everyone over 50 was herded into public institutions and eventually liquidated. A 1966 Rand Corporation study concluded that if the U.S. survived a nuclear war it would be "better off without old and feeble" citizens, and suggested that no provisions be made to care for the surviving elderly.

The U.S. has clearly not taken such advice. Most Americans, whether moved by religion or common decency, still try to follow the Fifth Commandment and "honor" their parents. But despite their concern, and frequently the anguish that marks their hard decisions about the elderly, the position of the aged in the U.S. has grown parlous. A couple of decades ago, most Americans who reached 65, the admittedly arbitrary age for retirement, could look forward to spending their last years in peace and security, respected and cared for by their families and friends. No longer. For an increasing number of Americans, the years after 65 are a time of growing uncertainty and isolation as, cut off from family, beset by illness and impoverished by inflation, they struggle not to enjoy the rest that they have earned but simply to survive.

Their problem is a pervasive, urgent one, both for the old and for their children. America as a society has yet to develop a practical, human policy for dealing with the woes of old age in a modern world. For those elderly Americans who can still manage--both physically and financially--life goes on much as it always has. But for those who cannot manage, the end of life, or at least of life as most people would want to live it, can be an agony. About a million, or 5% of the nation's elderly already live in nursing homes, too many of which are grim warrens for the unwanted. Tragically, the population of the nursing homes is growing. But so, too, is the public's concern over the plight of the old. Americans have yet to come up with the answers, but more and more are at least asking themselves the question that most must face sooner or later: What do we do with our parents?

There is no easy, single answer. In an earlier time, when most Americans lived in farms, the relatively few who reached old age simply stayed at home, inevitably working less and less but expecting and

getting as their rightful due more and more care from their families. Industrialization, urbanization, and the automobile have ended that. Most Americans no longer live on farms or in closely knit family groups. Evermore mobile, Americans by the tens of millions do not stay rooted in one place all their lives but pull up stakes, move and move again. Of those who hold on in the old home town, few live out their lives in one house. Married couples rarely stay with parents any more; even young singles are encouraged to strike out on their own. Those who leave frequently lose contact with their parents because of distance or because they are too busy to bother with the old folks, and may even be embarrassed by them. Says Anthropologist Margaret Mead, 73, and a grandmother: "The modern family, in its present form, is not equipped to care for old persons."

The problem is that there are more old people than ever to care for. In 1900 only 3.1 million, or one out of every 25 Americans, were over 65. Now 21.8 million, or one out of every ten, fall into this category. The reason for the rise is twofold. Modern medicine has cut infant mortality rates and increased the average life expectancy from 47 years in 1900 to 71.3 today. Since 1957 the U.S. birthrate has dropped (*Time*, Sept. 16), increasing the ratio of elderly to young people. If present population trends continue, those over 65 and those under 15 should account for 20% of the population by the year 2000.

...A significant number of today's elderly are, according to University of Chicago Professor Bernice Neugarten, "disproportionately disadvantaged." Many are foreign born, uneducated and unskilled. Far from all the aged are infirm, but 38% do suffer from some kind of chronic condition that limits their activities. Of these, fully half have serious problems and 5%, or one out of every 20, are homebound. About a third of all aged Americans are also plagued by poverty. Despite pensions, savings and Social Security, which will disburse $72 billion to 33.5 million recipients this year, fully 4,75 million of the nation's aged exist on less than $2,000 a year--well below the Federal Government's poverty line.

Depending on what they can afford and the extent to which they can take care of themselves or count on their families for help, the aged live in a wide variety of arrangements. For most, the accommodations are reassuringly familiar. More than two-thirds of America's elderly remain in the communities that they have known for most of their lives--and in the same homes. Most like the security of the familiar. For many, however, the decision not to pull up roots is economic as well as emotional: nearly 70% of older people own their own homes, humble as they may be. For owners, housing costs--utilities, taxes (often reduced for those over 65) and repairs--have long been relatively low. Now all of those costs are climbing shartly...

For some, old age means giving up solitary independence and moving

in with their children. Sometimes that works out well. Edna Segar, 74, who plays the piano in a Culver City, Calif., senior citizens' dance band, finds the arrangement fine. So do her son Donald, 54, and his wife Frances, 59. Says Donald" "You wouldn't throw your kids out, so you don't throw your parents out when they need you."

For others, caring for parents is a serious problem. Many urban Americans simply do not have the room to house an elderly father or mother, especially in New York and other cities where an extra room means paying an enormous increase in rent or buying a larger home than they can afford. Others claim that the presence of a parent in the home strains marital relations and puts tremendous pressure on children. Still others just cannot take the tension involved in caring for senile parents.

Many families also cannot handle the physical aspects of aging. The Jury family, of Clarks Summit, Pa., watched helplessly as "Grandpa" Frank Tugend faded. The Jurys kept the retired coal miner with them, bearing with him as he became confused and forgetful, cleaning up after him as he lost control of his bodily functions. In his lucid moments, the proud 81-year-old Tugend knew what was happening to him. One day he took out his false teeth and refused to eat any more. He had decided to die, and no one--not his doctor, not his family--could do anything to change that. His children and grandchildren cared for him with anguished tenderness until death claimed him three weeks later.

Few children have the devoted patience or endurance of Tugend's family. Each year more and more of them face the problem of deciding what to do when aged parents need more care than they can--or are willing to--give. In some cases, the answer is obvious: put them in a nursing home. The decision is often devastating for parents and children alike, and has ripped many families apart. Whatever happens, guilt hangs in the air like a sulfurous, corrosive fog. Even children who keep their parents at home generally feel remorse about what Paul Kirschner of the University of Southern California calls the "battered senior syndrome," which involves caring for aged parents but excluding them from many family activities. Those who place their parents in nursing homes often feel a still heavier burden of guilt for "abandoning" the old folks.

In many cases, what they have done, for whatever reason, amounts to abandonment. Mary Adelaide Mendelson, of Cleveland, a former community-planning consultant, has spent ten years studying institutions for the aged. Last year, in a book titled *Tender Loving Greed,* she concluded that U.S. nursing homes are a national scandal. She writes: "There is widespread neglect of patients in nursing homes across the country and evidence that owners are making excessive profits at the expense of patients."...

The best nursing homes deprive their patients of some independence. The worst deprove them of far more: their resources, rights and,

ultimately, their humanity. They are killer institutions. An investigation still under way in New York has dug out evidence of widespread abuse and exploitation of nursing-home patients. Inspectors who have made surprise visits to homes have found in the worst of them incontinent patients wallowing in their own filth, patients shot full of tranquilizers to keep them bovinely docile, others whose requests for help went unanswered and still others who were unfed or given the wrong foods and medication. They have also found many patients--unlike those at the now closed Towers Nursing Home in New York City--who were unwilling to complain for fear that they would be punished later by the attendants.

The crimes against the weak are not confined to New York. Authorities in Illinois are investigating not only suspected fraud but also the deaths of seven patients in a home in Rockford. California officials have turned up even more disturbing evidence. Los Angeles County investigators reported that a paralyzed woman at the Torrance Medical Convalescent Center, a 212-bed nursing home in Torrance, Calif., died after a nurse tried to feed her orally rather than through a stomach tube, then dismissed her gasping and flailing as an attempt to burn off "excess energy." The victim was not the only patient to die at Torrance, whose license to operate is being challenged. One patient died when he apparently leaped from a second-story window. "He probably jumped because of the conditions inside," said one angry health official....

...Regardless of their condition, the elderly deserve to be treated like human beings. Fortunately, action to guarantee such treatment has already begun. A special commission in New York has submitted an eleven-bill package that would include unannounced inspections of nursing homes, establish a stiff schedule of fines for violations of state standards and give the state the right to sue nursing homes that failed to provide proper care. The Minnesota state legislature has tightened up certification procedures and passed laws requiring close monitoring of nursing-home operations. Massachusetts authorities have shut down eight substandard homes and plan to close three more unless they are sold to someone who will run them properly.

Congress is also acting. Senator Frank Moss, chairman of a Senate subcommittee on long-term care, has introduced 48 bills that would, among other things, require 24-hr. attendance of a registered nurse, offer financial incentives to nursing-home operators by allowing higher payments for better care, and provide for full disclosure of the identities of all individuals involved in a nursing home's operation.

The enactment of pending legislation--indeed, even the enforcement of existing state and federal regulations--would go a long way toward ending the dehumanization and exploitation of those who can no longer care for themselves. But improving nursing homes will not help 95% of America's elderly. What will help them and those who will one day join their ranks is a realization that U.S. suffers from what Dr. Robert

Butler of Washington, D.C., calls "ageism"--or prejudice against the elderly--and a determination to end this cruel form of discrimination. "The tragedy of old age is not that each of us must grow old and die," writes Butler in his newly published book *Why Survive?* (Harper & Row; $15), "but that the process of doing so has been unnecessarily and at times excruciatingly painful, humiliating, debilitating and isolating through insensitivity, ignorance and poverty."

But, says Butler, much of this pain and humiliation can be eliminated. He and his fellow gerontologists urge those who want to help their parents--and other elderly--to help overhaul old policies and develop some new ones, particularly with regard to:

RETIREMENT. Most people assume that to be old is to be finished or "over the hill," and at least half of all American workers are now employed by companies that have institutionalized this assumption by forcing their employees to retire at age 65, if not earlier. The effects of this involuntary idleness can be traumatic. "One day they have life, the next day nothing," says Margaret Mead of unwilling retirees. "One reason women live longer than men is that they can continue to do something they are used to doing, whereas men are abruptly cut off--whether they are admirals or shopkeepers."

Most companies claim that mandatory retirement is necessary to maintain efficiency, preserve profits and clear the way for younger employees. But, gerontologists find the arguments unfair. There is no evidence that an individual's efficiency or creativity declines dramatically once he passes his 65th birthday; indeed, many people--from scientists to craftsmen to musicians--have done their best work during their declining years. Nor can it be assumed that most elderly Americans are too feeble to support themselves. At least half of those now over 65 are physically capable of doing a day's work. Mandatory retirement is, in fact, now under challenge. A former civil servant has filed suit to set aside the Federal Government's retirement policies. The American Medical Association has allied itself with him, insisting in a friend-of-the-court brief that there is no evidence that older workers are any less efficient than younger ones.

INCOME. It is pure romanticism, say more gerontologists, to assume that prudent people can provide adequately for their old age. Inflation in the 1970s can erode the value of the most liberal of pensions and shrink the worth of even the fattest savings accounts. Nor does Social Security, upon which most elderly Americans depend for at least a third of their income, enable most to live with any measure of financial security or comfort. A 65-year-old couple entering the plan this year and entitled to the maximum benefits, which they have paid for in taxes, draws only $474 a month. That inches them above the poverty line but hardly enables them to live beyond the bare-bones level. Besides, the average couple received only $310 a month.

To alleviate the financial plight of the elderly, experts recommend placing a reasonable floor, pegged to the actual cost of living, under retirement incomes, either by increasing Social Security benefits or supplementing them from other state or federal funds. They also recommend reforms in both Government and private pension systems, to assure that all workers who contribute to a pension plan will derive at least some benefits from it.

MEDICAL CARE. Most medical plans are designed to care for the elderly once they become ill. Gerontologists believe that the emphasis should be on preventing illness and preserving health and keeping the aged in the community....

ATTITUDES TOWARD AGING. Americans, says Butler, take an unhealthy and often unrealistic attitude toward aging, assuming that old people have no further contributions to make to society and should be excluded from it. Many of the elderly share this view, occasionally attempting to conceal evidence of their advancing years and withdrawing from an active life. Butler and others believe that attitudes must change if the aged are ever to be treated fairly in the U.S. They urge society to recognize the basic rights of old people to independence and security. Gerontologists also urge society to make better use of the elderly, drawing on their experience and talents and giving them a greater voice in matters that concern them. It is ridiculous, they agree, to have panels of 35-year-olds determining the wishes of and setting policy for the aged when the aged are better equipped to do the job.

Improvements in these areas are on the way. Congress has moved--albeit not very far--to tap the reservoir of talents the elderly have accumulated during their lives. It has approved $45 million for a variety of projects, including the Foster Grandparent Program, which pays oldsters for supervising dependent and neglected youngsters; $17.5 million for the Retired Senior Volunteer Program (RSVP), which pays out-of-pocket expenses to 100,000 involved in such community activities as entertaining the handicapped and visiting homebound parents; and a skimpy $400,000 for the Senior Corps of Retired Executives (SCORE), which reimburses some 4,500 retired executives for expenses incurred while counseling small businesses and community organizations.

Other programs are under way. One feeds the elderly, who often stretch their skintight budgets by subsisting on peanut butter sandwiches or skipping meals entirely. The nutrition section of the 1965 Older Americans Act, funded for $125 million this year, now provides 220,000 seniors with a hot meal a day through local nutrition centers of "Meals on Wheels" vans that deliver hot food right to the doors of the homebound aged.

More encouraging are the programs to keep the elderly in the community and out of institutions. Chicago, which set up the nation's

first municipal office for the aged in 1956, sponsors some 600 senior citizens' clubs, where they can meet to talk out their problems and organize to get things done. It also operates some 62 nutrition centers, where an estimated 3,800 come for a low-cost hot meal and some companionship.

At present, these programs reach and benefit only a handful of the nation's elderly. But the prospects for their expansion and for the development of other new approaches toward aging are brightening. One reason for this improved outlook is the growing recognition by most Americans that the country has a lot of catching up to do in its treatment of the aged and the new desire to change what more and more agree is an intolerable situation.

This urge to change things has been inspired in large part by the realization that other countries have done so much more than the U.S. in caring for the elderly. Sweden, Denmark and Norway have used part of the mountain of taxes collected from their citizens (as high as 50% of most salaries in Sweden) to ease many of the burdens of aging. In Sweden, city governments run housing developments where the aged can live close to transportation and recreational activities. Denmark, with a population of 5 million, houses many of its more than 600,000 elderly in subsidized houses or apartments and helps those who want to remain in their own homes by providing them with day helpers and meals. Those who need nursing homes find them a considerable cut above most of their American counterparts: with their excellent design, many look like modern hotels.

Another force behind the new impetus for change is the growing political power and militancy of the elderly themselves. Many groups--blacks, young people, women--have realized how much political muscle their numbers provide and organized in recent years to demand and get attention and help from federal, state and local officials. The aged are following their lead. No longer content to pass their days playing checkers or weaving potholders at senior citizens' centers, a growing number of elderly Americans are banding together to make their wishes known. Several thousand of them have joined a five-year-old group known informally as the Gray Panthers, whose leader, a retired Philadelphia social worker named Maggie Kuhn, 69, is dedicated to altering U.S. attitudes toward the aged. The Panthers have agitated for better housing and medical care and more employment opportunities for the elderly. "Most organizations tried to adjust old people to the system," says Miss Kuhn, "and we want none of that. The system is what needs changing."

The system is changing, and it is likely to change even further. Politicians, aware that the elderly are more likely to register and vote than the young, are listening when senior citizens speak. So are younger people. The new interest is encouraging. Americans have for too longed turned their backs on their old people. Now many are seeing them for

the first time, recognizing their plight and moving to help them. The interest and action are both humane and pragmatic. Today, millions of Americans are wondering what to do about their parents. Tomorrow, their children will be wondering what to do about *them*.

Section 5: Interests and Activities

Section 5 reprinted from *The Myth and Reality of Aging in America* - A study for the National Council on the Aging, Inc., 1975, pp. 54-61, by permission of Louis Harris and Associates.

A Description of the Sample

Trained Harris interviewers conducted a total of 4,254 in-person household interviews for this study during the late spring and early summer of 1974. The sample included a representative cross-section of the American public 18 years of age and over, selected by random probability sampling techniques. Scientific sampling techniques guaranteed each household in the continental United States an equal chance of being drawn into the sample.

In addition to a cross-section of the public 18 years of age and over, an additional representative sample of the public 65 and over was surveyed in order to provide adequate numbers of older people for detailed analysis of the conditions and attitudes of this group. Similarly, an additional cross-section of people 55 to 64 years of age was drawn into the sample to allow an in-depth analysis of the group that is approaching retirement age. Finally, a cross-section of the public and 65 and over would yield too few older blacks for a detailed look at their conditions and attitudes. For that reason, the sample design included an additional cross-section of blacks 65 and over. While the above-mentioned groups were sampled beyond their natural proportions in the U.S. population all subgroups were weighted back to their true proportions for their purposes of analysis....

Activities of Older People

An important ingredient in the overall image of older people is public perceptions of how most people over 65 spend their time. To the extent that older people are felt to spend their time engaged in constructive, contributing activities, it is safe to assume, the public views them as active, involved members of the community. To the extent they are felt to spend their time at retiring, sedentary activities, however, the public views them as worn-out, passive members of society.

At the outset, the public 65 and over were asked how in fact they spend their time. The most popular activity among the older public was "socializing with friends" (47% of the older public said they spend "a lot of time" at this activity), followed by "gardening or raising plants" (39%), "reading" (36%), "watching television" (36%), "sitting and thinking" (31%), "caring for younger or older members of the family"

(27%), "participating in recreational activities and hobbies" (26%) and "going for walks" (25%). Needless to say, participation in all these activities varies among older people according to age, income, etc....

The interesting finding is, however, that the older public seems no more or less likely to spend "a lot of time" on most of the pastimes tested than those under 65. Comparable numbers of the old and the young, for example, said that they spend a lot of time "sleeping," "reading," "sitting and thinking," "participating in fraternal or community organizations," "going for walks," etc. In three areas, those under 65 are much more likely than the older public to spend a lot of time: in caring for younger or older members of the family, in working part time or full time, and in participating in sports. The public 65 and older, on the other hand, is more likely to spend a lot of time watching television than is the younger public. But, apart from these four areas, the involvement of the young and the old in the activities mentioned was nearly comparable. (See chart next page.)

As has been seen throughout this report...public perceptions of the older population are very different from the way older people personally see themselves. In terms of how they spent their time, the public at large are far more likely to credit most people over 65 with spending their time at passive, sedentary activities than the older public say they actually do:

--While 36% of the older public say that they spend "a lot of time" watching television, a higher 67% of the total public expect that most people over 65 do. The fourth most popular activity mentioned by the older public, it was judged to be their number one pastime.

--While 31% of those 65 and over say they spend "a lot of time" sitting and thinking, twice that many (62% of the public at large) expect that this is how most people over 65 spend a lot of time. Their fifth most common activity according to older people surveyed, it was considered the second most frequent pastime by the total public.

--Only 16% of the older public say they personally spend "a lot of time" sleeping compared with a much higher 39% of the public who expect them to. According to the testimony of older people, sleeping is their tenth most time-consuming activity, although the public at large expects it to be their fourth.

--Similary, while only 15% of the 65 plus group say they spend "a lot of time" just doing nothing, a higher 35% of the public think this is how most people over 65 spend a lot of time.

On most other activities, however, the public at large appear to have a fairly realistic appraisal of the amount of time spent by most people over 65.

"A LOT OF TIME" PERSONALLY SPENT DOING VARIOUS ACTIVITIES BY PUBLIC 65 AND OVER COMPARED WITH PUBLIC 18 TO 64

	18-64 %	65 and Over %	Net Difference
Socializing with friends	55	47	-8
Caring for younger or older members of the family	53	27	-26
Working part-time or full-time	51	10	-41
Reading	38	36	-2
Sitting and thinking	37	31	-6
Gardening or raising plants	34	39	+5
Participating in recreational activities and hobbies	34	26	-8
Watching television	23	36	+13
Going for walks	22	25	+3
Participating in sports, like golf, tennis or swimming	22	3	-19
Sleeping	15	16	+1
Participating in fraternal or community organizations or clubs	13	17	+4
Just doing nothing	9	15	+6
Doing volunteer work	8	8	-
Participating in political activities	5	6	+1

PUBLIC 65 AND OVER WHO SPEND "A LOT OF TIME"
DOING VARIOUS ACTIVITIES COMPARED WITH TOTAL PUBLIC
WHO THINK "MOST PEOPLE OVER 65"
SPEND "A LOT OF TIME" AT THESE ACTIVITIES

	Public 65 and Over Who Spend "A Lot of Time" Personally		Total Public Who Think "Most People Over 65" Spend "A Lot of Time"		Net Difference
	Rank	%	Rank	%	
Socializing with friends	(1)	47	(3)	52	+ 5
Gardening or raising plants	(2)	39	(5)	45	+ 6
Reading	(3)	36	(6)	43	+ 7
Watching television	(4)	36	(1)	67	+31
Sitting & thinking	(5)	31	(2)	62	+31
Caring for younger or older family members	(6)	27	(11)	23	- 4
Recreational activities & hobbies	(7)	26	(9)	28	+ 2
Going for walks	(8)	25	(8)	34	+ 9
Fraternal or community organizations or clubs	(9)	17	(10)	26	+ 9
Sleeping	(10)	16	(4)	39	+23
Just doing nothing	(11)	15	(7)	35	+20
Working part or full time	(12)	10	(14)	5	- 5
Volunteer work	(13)	8	(12)	15	+ 7
Participating in political activities	(14)	6	(13)	9	+ 3
Participating in sports like golf, tennis or swimming	(15)	3	(15)	5	+ 2

PUBLIC WHO THINK "MOST PEOPLE OVER 65" SPEND
"A LOT OF TIME" DOING VARIOUS ACTIVITIES"
(Public 18 to 64, Compared with Public 65 and Over)

	18-64[1]	65 and Over[2]	Net Difference
	%	%	
Watching television	68	64	- 4
Sitting and thinking	66	42	-24
Socializing with friends	53	42	-11
Gardening or raising plants	47	34	-13
Reading	45	33	-12
Sleeping	42	25	-17
Just doing nothing	37	27	-10
Going for walks	35	24	-11
Participating in recreational activities and hobbies	28	24	- 4
Participating in fraternal or community organizations or clubs	26	22	- 4
Caring for younger or older members of the family	24	21	- 3
Doing volunteer work	15	10	- 5
Participating in political activities	9	10	+ 1
Working part-time or full-time	5	6	+ 1
Participating in sports, like golf, tennis or swinning	5	5	--

[1] People Who Think "Most People Over 65" Spend "A Lot of Time"

[2] People 65 and Over Who Think "Most People Over 65" Spend "A Lot of Time"

While the public 65 and over were far less likely than those 18 to 65 to exagerate the amount of time most people over 65 spend at sitting and thinking, sleeping and just doing nothing, the older public are still more likely to attribute to most older people sedentary pastimes than they say they personally are involved in themselves. On most other activities, the public 65 and over tend to feel that most of their contemporaries spend about as much time as they personally do. (See chart on previous page.)

Observation

The above measure of the amount of time spent at various activities must be seen as a subjective and relative measure. To begin with, what may seem to one person like "a lot of time" to spend at a given activity may seem like "hardly any time at all" to another. Furthermore, "a lot of time" spent gardening may be in no way comparable to "a lot of time" spent watching television. For this reason, the above results should not be interpreted as absolute measures of how much time older people spend at various activities. Instead, they are valuable as indications of the kinds of activities that people see themselves involved in, and the degree of involvement. It is a significant finding therefore that large proportions of the public at large (and the young even more than the old) attribute to most older people greater involvement in sedentary, private and isolated activities than the older public attest to personally. It is no wonder that the public at large considered "not enough to do to keep busy" a serious problem of older people, although those 65 and over deny this is a problem.

ACTIVITY ONE

MEETING THE REQUIREMENTS OF OBJECTIVE ONE

Objective One

Identify and describe in writing: (1) at least one bias, stereotype, or attitude about the elderly which you personally hold and the possible effects of that bias on your counseling of the elderly; (2) at least one attitude you have regarding the elderly and the possible client benefits.

Successful achievement of this objective will require writing two brief paragraphs presenting your answers to four given questions.

You've had a chance now to look at many of the stereotypes society has developed about the elderly. An important objective of the preceding activities and discussions is to have you identify your own biases and stereotypes about the elderly as well as to reinforce your positive attitudes.

What have you discovered about yourself? What attitudes do you feel you will need to overcome and how do you think those attitudes could affect your counseling of the elderly? What positive attitud are you able to bring to the counseling session and how might these help your counselor-client relationship?

On a separate sheet of paper write two brief paragraphs answering the following questions:

Paragraph One

What attitudes do you hold about the elderly that could be particularly beneficial in your role as counselor.

What client benefits could you expect to be derived from the positive attitudes you have indicated?

Paragraph Two

What bias, stereotype, or attitude have you identified within yourself that could adversely affect your counseling of the elderly?

How do you think the bias could affect your relationship with the elderly client and the outcome of the counseling?

Determining the Successful Achievement of Objective One

Fill in the name of the participant whose paper you are checking:

_____

Instructions

Use the following checklist to certify that the participant named above has successfully met the requirements of Objective One.

The paragraphs contain:

_____ 1. An example of a personal attitude about the elderly which could be beneficial in the role of counselor.

_____ 2. A brief discussion of possible client benefits which could be derived from the positive counselor attitudes indicated.

_____ 3. One example of a bias, myth, stereotype, or attitude which the participant feels s/he holds about the elderly.

_____ 4. A description of how that bias, myth, stereotype, or attitude might affect the counselor-client relationship.

Sign and date this checklist and return it and the paper to the person named above.

Paper checked by:_____

Date:_____

SECTION TWO

CONCERNS OF CHANGE AND ADJUSTMENT OF THE OLDER ADULT

Life satisfaction in the later years results from some interaction among one's earlier ones. Or you could say that your old age depends on your young age. This could be just another way of stating that people basically age the way they live. If you have been a worry-wart as a young person, chances are you will continue to be a worry-wart as an older person. If you enjoyed social activities as a young person, then chances are you will be socially inclined in your old age.

Significant changes such as financial, health, family roles and status can definitely influence the older person's living patterns. It is not unusual for retired people to live on drastically reduced "fixed" incomes. The change in identity from a worker and a provider to a person who is now "underfoot" can cause new stress in family relationships. For many older poeple the concern for adequate health maintenance becomes both a personal and financial burden.

The counseling concern that surrounds all these factors mentioned is one of preparing the older adult to deal with change. To assist clients through the process of adapting and accommodating new factors into their established daily routines is indeed the challenge inherent in working with the older person--the influence of one's present state of life has a great influence on how a person perceives his/her total life experience. The later years of life are often viewed as the conflict of gain and loss. For each year gained, the loss of economic and personal comforts becomes greater.

The low income problem of the elderly comes at a time when other resources are diminishing. The possibility of part-time employment or borrowing money against future prospects is limited as well. The most influential factors that contribute to lower income levels among the older adults are education, race, and sex.

Not all issues of the older adult deal with negative concerns. The area of life satisfaction and enjoying the fullness of one's life

cycle is also common. Studies have been conducted to investigate what are high and low sources of morale for the older adult.

Clark and Anderson (1967) collected data from interviews with 65 elderly people in San Francisco, half of whom lived in the community and half in long-term care facilities. This study indicated that entertainment and diversions were the most frequently reported sources of high morale.

Sources of High and Low Morale for 65 Elderly San Francisco Residents
(Clark and Anderson, 1967)

SOURCES OF HIGH MORALE	PERCENTAGE REPORTING THIS FACTOR
Entertainment and Diversions	69
Socializing	57
Productive Activity	56
Physical Comfort (other than health)	52
Financial Security	46
Mobility and Movement	40
Health, Stamina, Survival	20

SOURCES OF LOW MORALE	PERCENTAGE REPORTING THIS FACTOR
Dependency (financial and physical)	60
Physical discomfort or sensory loss	57
Loneliness, bereavement, loss of nurturance	50
Mental discomfort or loss	38
Loss of prestige or respect	12
Fear of dying	10

To understand why some people have difficulties while others have none is thought to require an appreciation of the interplay between biological, social, and personal changes as they come to expression in an individual coping style.

The range of individual differences in the biological aging process is great. Studies have indicated that although creativity, motivation, and emotional reactions can be reduced by aging, counselors need to be aware of the impact of restricted social and educational environments available to the older adult. Sensory impairments such as sight or hearing loss and the altering of taste and smell can be expected. The majority of older adults have some kind of chronic health problem requiring visits to the doctor, special diets or rehabilitative therapy.

The sociological impact of aging is an important area to consider when examining factors that affect the quality of life of the older adult. Society's perception of aging (value of age) and the development of new roles are common challenges of this special group. Most people 65 are either living alone or with only their spouses. Another change in family relationships is identified as "role reversal." The elderly mother and/or father are not associated with providing emotional, social or financial support, rather the children now assume the "parenting" role.

The quote "you married me for dinner, but not for lunch" accents another social factor of aging. Many marriage relationships are developed around the couple's work identity and schedule. The retirement period can cause readjustment to the husband-wife relationship.

Acknowledging the factors that can be influential to the impact of aging, Kalish (1975) offers four possible definitions of successful aging:

1. A way of life that is socially desirable for this age group.
2. Maintenance of middle age activities.
3. A feeling of satisfaction with one's present status and activities.
4. A feeling of happiness with one's life.

To encourage "successful" aging, older adults can benefit from information about what it means to become elderly. Learning effective methods to cope with change and maintain self-esteem can make the aging process less negative.

The National Council on Aging (Louis Harris and Associates, 1975) conducted a poll representing a cross-section of adults to investigate attitudes about aging. The survey was designed to measure the gap between the expectations and the actual experience of being old. The problems identified were less overwhelming than most would expect.

Differences Between Personal Experiences of Americans 65 and Over and Expectations Held by Other Adults About Those Experiences (Louis Harris and Associates, 1975)

The figures below compare very serious problems experienced by the elderly themselves with what the public expects the elderly to experience.

	Elderly Experience %	Public Expectation %	Net Difference %
Fear of crime	23	50	+27
Poor health	21	51	+30
Not having enough money to live on	15	62	+47
Loneliness	12	60	+48
Not having enough medical care	10	44	+34
Not having enough education	8	20	+12
Not feeling needed	7	54	+47
Not having enough to do to keep busy	6	37	+31
Not having enough friends	5	28	+23
Not having enough job opportunities	5	45	+40
Poor housing	4	35	+31
Not having enough clothing	3	16	+13

Most people over 65 regret that they did not plan better for the years ahead. They expressed concern that facts about life in the later

years had not been available to them. The aged suffer from the insulation of problems of the later life cycle and they become victims of their own stereotypes.

Much of the negative age-socialization, or the accepting of the stereotype that old means useless does conspire against the older adult maintaining adequate social status. Yet the desire for positive identity and the need to challenge one's potential remains a concern throughout the life cycle.

John Flannagan and Darlene Russ-Eft (1977) conducted a survey to study this very area. This investigation examined the quality of life components important to males and females at ages 35, 50, and 70. As you will note there is very little change in people's response to their quality of life needs at the different age levels. (See table on following two pages.)

The stress and losses that come with increasing age dictate a need to cope and adjust to the new life pattern. It is not unusual for the older adult to maintain the same adjustment pattern that was prevalent in the younger years.

The older person's potential for growth and development can be supported by the information reviewed. Yet the strength of socioeconomic factors still influences the perceptions of many people in regard to assuming what being old is all about. The danger becomes even greater when the older people themselves are mirroring this negative image and accept the role of being just "old."

Education and Quality of Life

Percentages of a Sample of 1,000 30-Year Olds, 600 50-Year Olds, and 600 70-Year Olds Reporting Each of the 15 Components as Important or Very Important to Their Quality of Life* (Flanagen and Russ-Eft, 1977)

Component	Male			Female		
	30	50	70	30	50	70
PHYSICAL AND MATERIAL WELL-BEING						
A. Material comforts--things like a desirable home, good food, possessions, conveniences, an increasing income, and security for the future.	80	85	87	75	86	87
B. Health and personal safety--to be physically fit and vigorous, to be free from anxiety and distress, and to avoid bodily harm.	98	96	95	98	98	96
RELATIONS WITH OTHER PEOPLE						
C. Relationships with your parents, brothers, sisters, and other relatives--things like communicating, visiting, understanding, doing things, and helping and being helped by them.	68	63	60	83	76	78
D. Having and raising children--this involves being a parent and helping, teaching, and caring for your children.	84	85	83	93	92	88
E. Close relationships with a husband/wife/a person of the opposite sex.	90	88	85	94	83	46
F Close friends--sharing activities, interests, and views; being accepted, visiting, giving and receiving help, love, trust, support, guidance.	71	76	70	79	80	87
SOCIAL, COMMUNITY, AND CIVIC ACTIVITIES						
G. Helping and encouraging others--this includes adults or children other than relatives or close friends. These can be your own efforts or efforts as a member of some church, club, or volunteer group.	70	71	64	72	74	78
H. Participation in activities relating to local and national government and public affairs.	47	62	64	42	58	58
PERSONAL DEVELOPMENT AND FULFILLMENT						
I. Learning, attending school, improving your understanding, or getting additional knowledge.	87	68	50	81	67	60

J. Understanding yourself and knowing your assets and limitations, knowing what life is all about and making decisions on major life activities. For some people, this includes religious or spiritual experiences. For others, it is an attitude toward life or a philosophy.	84	84	80	92	90	88
K. Work in a job or at home that was interesting, rewarding, worthwhile.	91	90	55	89	85	59
L. Expressing yourself in a creative manner in music, art, writing, photography, practical activities, or in leisure time activities.	48	39	36	53	54	58
RECREATION						
M. Socializing--meeting other people, doing things with them, and giving or attending parties.	48	47	49	53	49	60
N. Reading, listening to music, or observing sporting events or entertainment.	56	45	52	53	56	63
O. Participation in active recreation--such as sports, traveling and sightseeing, playing games or cards, singing, dancing, playing an instrument, acting, and other such activities.	59	48	47	50	52	52

*"At this time in your life, how important to you is_____?"

ACTIVITY TWO

Each participant will list a positive and negative incident that they can recall that influenced an older person's accommodation to change in life roles.

Complete the following. Identify and describe in writing:

1. Think of the last time you observed an older adult experiencing a positive accommodation to her/his change in life role status. List at least two factors which influenced the positive change.

2. Think of a recent time when you observed an older adult experiencing a negative accommodation to change in life roles. List at least two factors which influenced the negative change.

Successful achievement of this objective will require two brief paragraphs describing the incidents described above as evidenced by the following checklist.

Fill in the name of the participant whose paper you are checking.

_____

Instructions: Use the following checklist to certify that the participant named above has successfully met the requirements of Objective Two.

The paragraphs contain:

_____ 1. A positive incident of life role accommodation with two causative factors identified.

_____ 2. A negative incident of life role accommodation with two causative factors identified.

Sign and date this checklist and return it and the paragraphs to the person named above.

Paper checked by:_____

Date:_____

SECTION THREE

EFFECTIVE ATTENDING AND LISTENING SKILLS

Communication, like other daily life experiences, could be something that people tend to take for granted. One could consider that the fact that words were spoken, means they were also understood. The continual emphasis on listening with "open minds" as well as "open ears" is a skill worthy of consideration.

Much of the time the listener's attention is captured by vivid impulses such as loud noises or dramatic contrasts. These impulses command one's attention because they force themselves into the listener's consciousness. When the senses give way to the pressure of physical impulses, the primary or basic level of attending has been affected.

When a listener begins to select or sort through all the words and stimuli being transmitted and relies on past experiences to give meaning to what is being said, then secondary attention level results. It is at this secondary level, the level when the listener is interpreting through his/her frame of reference, that the skill of listening attentively and openly becomes complex.

Good listening skills will require a person to operate at both primary and secondary levels. To tune into someone else's perspective and not block the communication with one's own values or experiences, is the core of effective listening behavior. Accurate listening skills will require a person to listen with her/his eyes as well as ears. One should be sensitive to body language, such as body movement, facial change or looking into another person's eyes...comfortably...when talking.

The obvious concern for competent attending and listening behavior is a critical concern, particularly when one is involved with older adults. Habits, attitudes and previous experience with older adults can influence and possibly block new information being offered to the listener.

Kelter (1973) suggests some general considerations for developing effective listening skills.

1. We can develop habits of seeking beyond what we expect a situation to produce.

2. We can develop habits of focusing attention on the speech of others.

3. We can prepare to listen.

4. We can check our own role and purpose in any given communication.

5. We can examine the role and purpose of the speaker.

6. We can determine how we wish to relate to the speaker.

7. We can identify the style and language of the speaker.

8. We can, to whatever degree possible, determine how the speaker sees the world and follow the context of his/her world.

9. We can determine the relevancy of bits of information to our own needs and purposes.

10. We can test the reliability of the information we get from a speaker.

11. We can deliberately attempt to perceive the relevant stimuli of the speaking situation from as many viewpoints as possible.

Listening requires the use of both visual (attending) and auditory (listening/hearing) capabilities. It is not unusual for these skills to be considered an elementary function of communication. Even the familiar saying, "Well I can't do much for you, but I can at least listen," could suggest the priority sometimes given to listening. But it is so often this very assumption, that anyone can be a good listener, that can complicate the best intentions of people working with the older adult. To truly prepare oneself to listen accurately and openly to another speaker requires a conscious effort on the part of the listener to seek beyond what he/she expects to hear. This section emphasizes the attending/listening aspect of communication. For further information in regard to the verbal responding aspect of communication, the reader should see National Consortium Module No. 13, *Utilizing Strategies for Adult Guidance*.

ACTIVITY THREE

Listening is a constantly shifting process. A person's listening ability is influenced by his/her feelings, experiences and motivations. The following exercise will assist you in developing your listening skills.

Directions

First, complete the following lists in order to have guidelines for the role playing which follows.

When I think of myself at 70, I would describe my:

Activities as:

1. _____
2. _____
3. _____

Personal Attitudes to be:

1. _____
2. _____
3. _____

People in my life:

1. _____
2. _____
3. _____

After you complete the list, assume your subgroup of four. Each of you assumes a role of (a) speaker, (b) listener, or (c) observer.

Role of speaker--Discuss with the listener, using your list for discussion suggestions, your activities, friends, etc., as a 70-year-old person (three minutes).

Role of listener--Listener does not make any verbal responses. At the end of the three minutes, listener will paraphrase what s/he has heard.

Role of observer--Observers use the rating on the following page to evaluate the listener's attending and listening skills.

ATTENDING AND LISTENING SKILLS
Rating Scale

1 = not observable
2 = moderately observable
3 = highly observable

Attending Skills	1	2	3
1. Attention was on speaker.	___	___	___
2. Established comfortable listening rapport (such as the relationship encouraged self expression).	___	___	___
3. Responded to body language (such as leaned forward when speaker's voice became softer).	___	___	___

Listening Skills			
1. Gave accurate interpretation (such as the listener paraphrased at least 80% of what was said).	___	___	___
2. Sensitive to the speaker's feeling (such as listener picked up on the joy expressed).	___	___	___
3. Heard the speaker's viewpoint (such as the listener could paraphrase negative comments without injecting personal opinion).	___	___	___

TOTAL POINTS _____

Evaluation of the Exercise

After each time one member of your subgroup role plays, the observers should share their ratings with the listener and the speaker. Successful completion of this activity is a rating of 12-15 points.

SECTION FOUR

PROBLEM SOLVING STRATEGIES FOR THE OLDER ADULT

The awareness of individual differences (i.e. age, sex, culture) is a central determinant of the counseling strategy selected. Oftentimes specific training is necessary so that counselors are given the information about the needs of the particular group and also an opportunity to evaluate their own attitudes, values, and biases regarding this population. To effectively implement a counseling program for the older population, information about their particular needs warrants investigation.

Butler and Lewis (1977) list the following as special characteristics of older people that the counselor should be sensitive to:

Desire to leave a legacy. Older people have a need to leave something of themselves behind. The need to feel that their life was meaningful gives a continuity to the living and dying process. Some will express this need in their family (children); others may leave art, material goods, as a reminder of their participation in life.

The "elder" function. The older person could adopt the role of wisdom and want to share with others the wealth of experience his/her life has enjoyed. An important element of self-esteeem and position is felt when the elder is given an opportunity to share either through counseling, sponsoring, or giving guidance to younger people.

Attachment to familiar objects. Objects such as pets, scrapbooks, old letters provide comfort and continuity to the older person. These familiar possessions can be a source of security and satisfaction for the aged and fear of loss of these possessions is frequently a fear of the older person.

Change in sense of time. The awareness of time escaping them or being on the "shadow" side of life is a common characteristic of the older person. The focusing on very basic elements of life--children, nature, plants--can assume greater significance as people grow older. Living each day to the fullest, an acute sense of "present" time is

a result of the change in the sense of time.

Sense of the life cycle. We are now using older people for recording "oral" history. To appreciate the fullness of the life span, the beginning and the ending, is a more positive attitude towards the growth of old age. Older people are being asked to verbally record history as they have lived it through their life cycle.

Creativity, curiosity and surprise. The ability to be interested, motivated and a learner doesn't necessarily diminish with age. The fact that many older workers maintained uninteresting jobs for much of their lifetimes because the work ethic in operation at the time of their youth directed them to early vocational decisions could open possibilities for discovering untapped potential in their elder years. Many older people have learned new skills, established new interests because of the opportunity of time and support given to them in their older years.

Sense of consummation or fulfillment of life. The sense of reflection over one's life cycle, to enjoy the experience of living the review of one's years, can be a gratifying one. To have met the challenge of everyday conflict, reflect on the quality of life spent, can be influential on how the older person completes the cycle and ends the circle of life.

When counseling the older adult, common issues can arise in the counseling session. The time element is usually of great concern to the older person. Sometimes you will only see the person for one visit. The significance of the contact can be underestimated.

The issue of a "second chance" or a "new start" is common. This could be a cue for change and a desire to undo past behaviors.

The area of grief and restitution are central to the elderly's concern. The efforts made to deal with loss of loved ones and awareness of one's own dying process are important goals of counseling with the older adult.

The ability to exercise some control in one's life or the right to assert one's belief systems is still another issue in counseling the older adult. A sense of helplessness can diminish the degree of self-

esteem older people feel for themselves.

The issues presented here have a common challenge of change and adaptation. Effective counseling strategies that encourage successful accommodation to the aging process are vital techniques to use when working with older people. A counselor should be one who can facilitate growth and change by modeling behaviors that encourage openness, regard, and empathy to the client. To be sensitive to the unique issues that older people face is paramount to working effectively with this group of people.

Problem solving strategies can serve as a valuable tool for the counselor. The majority of counseling sessions will be concerned with the client sharing a problem that needs to be discussed. It is vital to the quality of the counseling relationship that the counselor does not solve the problem "for" the client.

There are common elements in the act of listening to problems. They are helping the client (1) to go beyond problem awareness, to help him/her to carefully define the problem; (2) to aid the client to set his/her goal of what s/he wants to do about the defined problem; and (3) to deal with the obstacles that may arise in the achieving of that goal. For example:

> Problem: (Mrs. Jones speaking) My sister has died and left me her share of the furniture that graced the old family home. I want to keep that furniture and be able to display it so people can appreciate fine old antiques.
>
> Goal: I think I'll have to get a larger apartment for me to accommodate both my possessions and those my sister left me.
>
> Obstacle: I can't afford the two-bedroom apartment it would take in my building to properly display all the furniture.

Helping problem solve here would be giving all three steps attention. However, trying to solve the problem on the client's terms is important, if at all possible. For example, following through on the stated steps above should come first. If the obstacle seems insurmountable, alternatives could be discussed as in the following questions. For example, does she want all of the furniture? If not, would taking just

certain pieces reduce her need? If she could sell some, would it help her gain more space for the rest? Are there things of her own she would be willing to part with in order to keep more of the antiques?

If moving still prevails as the solution to the goal stated above, certain considerations should be discussed such as (1) it must be in my price range, (2) it must meet my space requirements, and (3) it must meet my standards in neighborhood environment, such as transportation, friends and personal safety.

As you review this example in group discussion, what special characteristics of older people (i.e. desire to leave a legacy) described above apply here?

The problem-solving process can be an effective technique of exploring both personal and group concerns. The process requires that decisions are made throughout the discussion.

As people mature and gain life experiences, they become increasingly unique. The above method of problem solving is effective for dealing with this "uniqueness" of each person.

ACTIVITY FOUR

Divide into groups of four: (1) counselor (2) client (3) two observers.

Each of you use a different case study sample in the pages which follow as your situation for role playing activity.

Switch until all participants have been involved in the counselor and client roles for 10 minutes.

Each "counselor" should be given at least two rating scales from two observers.

Each counselor should hold the following things in mind when assisting the client in the following areas of concern:

1. Is the problem actually clear to the client? Is it part of a larger problem? Can it be brought down to size?

2. What does the client really want to happen once s/he has "solved" the problem?

3. Have all the obstacles been considered? Which ones seem to be bothering the client most?

4. What conditions need to be considered to reach the desired goal?

COUNSELOR RATING SCALE

	Clear 4	Moderately Clear 3	Slightly Clear 2	Not Clear 1
1. Problem defined				
2. Goal defined				
3. Obstacles considered				
4. Alternatives discussed				

Successful achievement means a score of at least 12.

Case Study No. One - Mr. D

Mr. D had enjoyed a very successful career in the music business. He considered himself to be a "self-taught" person and earned a comfortable income, without the benefit of a college education.

Mr. D is 62 and enjoying retirement with his wife. Recently his wife registered for classes at a local community college. Mr. D became interested in the classes and experiences she was having. He thought that returning to school after all these years might seem foolish for him. He had no goals or need to seek employment, but considered taking classes "just for fun."

His wife noticed a senior center on campus. She encouraged her husband to make an appointment with a counselor to discuss his concerns about re-entering school.

Case Study No. Two - Mrs. R

Mrs. R is a 64-year old widow. She had lived on the East Coast for 30 years with her husband. Most of her children were in California. After the death of her husband, the children encouraged her to move closer to them.

Mrs. R sold the house and all her belongings and decided to make a "fresh start" in California. The children were kind and supportive and she settled in an apartment close to them. Although she enjoyed the climate and her family, Mrs. R found herself feeling very lonely and out of place in her new surroundings. She felt her new widowhood role was very isolated, and she missed her friends back east. She was very shy about making new contacts or engaging in social activities.

She read about a Widow-to-Widow counseling group available at the Senior Center in her community. She didn't know if this would really help her, but she felt so helpless coping with the stresses of widowhood she decided to call for an appointment with the counselor to get more guidance about this program.

Case Study No. Three - John and Marion

Marion, who had been single all her life, had been retired for three years and was enjoying her free time. During one holiday in Florida she met a very nice man. John had been a widower for four years and had three married children. Marion and John decided they would like to share their life and had a quiet wedding in Florida before returning to John's home in Boston.

The couple were very happy and were well received by all the family except John's youngest daughter. The couple felt the daughter was disturbed by the fact her father remarried and was disloyal to the memory of her mother. Marion wanted to communicate her feelings to the daughter, but was at a loss for a way to begin.

The couple noticed a church bulletin that advertised counseling sessions for families. John and Marion were both feeling a need to talk with someone about their dilemma. They decided to make an appointment with the counselor.

Case Study No. Four - Mr B

Mr. B was a 66-year-old retired plumber. He had always worked part-time, even as a retired person because he liked to be busy. Although he enjoyed the plumbing business, he had always dreamed of being an artist. Because he had been so involved with his business, he never felt had had time to take an art class.

Mr. B found himself thinking more and more about painting. He felt that if he were going to do anything about it, he'd better make a decision because time was moving very fast. He was also feeling maybe it was too late to start anything new. Mr. B thought an art teacher wouldn't want to waste his/her time teaching an old man.

One of his neighbors told him about a special Saturday class in beginning painting that was offered very close to his home. He called and made an appointment to talk to the program coordinator.

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Note: The list of 52 National Consortium staff development modules can be found immediately following the Coordinator's Guide.

APPENDIX A

SCORING AND DOCUMENTATION FOR FACTS ON AGING: A SHORT QUIZ

Reprinted by permission of the publisher, *The Gerontologist*. Facts on Aging: A Short Quiz. Erdman Palmore. *The Gerontologist*, Vol. 17, No. 4, 1977, pp. 316-320.

Scoring

The key to the correct answer is simple: all the odd numbered items are false and all the even numbered are true. So far, no one taking the quiz has guessed this pattern of correct answers.

Documentation

(1) The majority of old people are not senile (i.e., defective memory, disoriented, or demented). Only about 2 or 3% of persons age 65 or over are institutionalized as a result of psychiatric illness (Busse & Pfeiffer, 1977). A series of eight community surveys found the prevalence of psychosis (of all types) to range from 4 to 8% (Riley & Foner, 1968). Thus, all the evidence indicates that there are less than 10% of the aged who are disoriented or demented. It is more difficult to get accurate estimates of the proportion with defective memories, partly because of the different types of memory defects and different methods of measuring it. However, most studies agree that there is little or no decline with age in short-term memory storage capacity (using the digit span test). Four studies did find large age differences in free recall of words, but two of them found no age differences in recognition of words in a list (Woodruff & Birren, 1975). As for long-term memory, various community surveys have found less than 20% of the aged who cannot remember such things as the past President of the United States, their correct age, birth date, telephone number, mother's maiden name, address, or the alphabet (Botwinick, 1976; Pfeiffer, 1975). Thus, it is clear that the majority of aged to not have such serious memory defects.

(2) All five senses do tend to decline in old age. Most studies agree that various aspects of vision, hearing, and touch tend to decline in old age. Some studies of taste and smell have not found a significant decline, but the best evidence indicates increases in taste and smell thresholds with age (Riley & Foner, 1968). Studies of structural atrophy in the tongue and nose with old age support the experimental evidence of decline in taste and small (Birren, 1969).

(3) The majority of persons past age 65 continue to have both interest in, and capacity for, sexual relations. Masters and Johnson (1966) found that the capacity for satisfying sexual relations continues into the decades of the 70s and 80s for healthy couples. The Duke Longitudinal Studies found that sex continues to play an important role in the lives of most men and the majority of women through the seventh decade of life (Palmore, 1974).

(4) Lung capacity does tend to decline in old age. Both vital lung capacity (the volume of air that can be forcibly expelled in one breath) and maximum breathing capacity (the volume of air that can be moved in and out of the lungs in 15 seconds) declines on the average from age 30 onward (Shock, 1962).

(5) The majority of old people do not feel miserable most of the time. Studies of happiness, morale, and life satisfaction either find no significant difference by age groups or find about one-fifth to one-third of the aged score "low" on various happiness or morale scales (Riley & Foner, 1968). A recent national survey found that a fourth of persons 65 or over reported that "This is the dreariest time of my life"; while a majority said "I am just as happy as when I was younger" (Harris, 1975).

(6) Physical strength does tend to decline in old age. Studies of various kinds of muscular strength show declines in old age compared to young adulthood of 15 to 46% (Birren, 1959).

(7) Only 4.8% of persons 65 or over were residents of any long-stay institutions in 1970 (U.S. Census, 1970). Even among those age 75 or over only 9.2% were residents in institutions.

(8) Drivers over age 65 do have fewer accidents per person than drivers under age 65. Older drivers have about the same accident rate per person as middle-aged drivers, but a much lower rate than drivers under age 30 (National Safety Council, 1976). Older drivers tend to drive less miles per year and apparently tend to compensate for any declines in perception and reaction speed by driving more carefully.

(9) The majority of older workers can work as effectively as younger workers. Despite declines in perception and reaction speed under laboratory conditions among the general aged population, studies of older workers (the 12% who are able to continue employment) under actual working conditions generally show that they perform as well as young workers, if not better than younger workers, on most measures. When speed of reaction is important, older workers sometimes produce at lower rates, but they are at least as accurate and steady in their work as younger workers. Consistency of output tends to increase by age, as older workers perform at steadier rates from week to week than younger workers do. In addition, older workers have less job turnover,

less accidents, and less absenteeism than younger workers (Riley & Foner, 1968).

(10) About 80% of the aged are healthy enough to engage in their normal activities. About 5% of those over age 65 are institutionalized and another 15% among the noninstitutionalized say they are unable to engage in their major activity (such as work or housework) because of chronic conditions. This leaves 80% who are able to engage in their major activity (National Center for Health Statistics, 1974).

(11) The majority of old people are not "set in their ways and unable to change." There is some evidence that older people tend to become more stable in their attitudes, but it is clear that most older people do change and adapt to the many major events that occur in old age such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of society, although at a somewhat slower rate than for younger people (Cutler & Kaufman, 1975; Glenn & Hefner, 1972).

(12) Old people usually take longer to learn something new. Experiments have consistently shown that older people take longer than younger people to learn new material (Botwinick, 1967). Studies of on-the-job trainees also show that older workers tend to take somewhat longer to learn new jobs (Riley & Foner, 1968).

(13) But, it is not impossible for most old people to learn new things. The same studies (cited in #12) also show that most older persons can eventually learn new things about as well as younger persons, if given enough time and repetitions of the material to be learned.

(14) The reaction time of most old people tends to be slower than that of younger people. This is one of the best documented facts about the aged on records. It appears to be true regardless of the kind of reaction that is measured (Botwinick, 1967).

(15) Most old people are not pretty much alike. There appears to be at least as much difference between older people as there is at any age level; there are the rich and poor, happy and sad, healthy and sick, high and low intelligence, etc. In fact, some evidence indicates that as people age they tend to become less alike and more heterogeneous on many dimensions (Maddix & Douglas, 1974).

(16) The majority of old people are seldom bored. Only 17% of persons 65 or over say "not enough to do to keep busy" is a "somewhat serious" or "very serious" problem (Harris, 1975). Another survey found that two-thirds of the aged said they were never or hardly ever bored (Dean, 1962). The Duke Adaptation Study found that 87% of those 65 or over said they were never bored in the past week.

(17) The majority of old people are not socially isolated and

lonely. About two-thirds of the aged say they are never or hardly ever lonely (Dean, 1962), or say that loneliness is not a serious problem (Harris, 1975). Most older persons have close relatives within easy visiting distance and contacts between them are relatively frequent (Binstock & Shanas, 1976). About half say they "spend a lot of time" socializing with friends (Harris, 1975). About three-fourths of the aged are members of a church or synagogue (Erskine, 1964), and about half attend services at least three times per month (Catholic Digest, 1966). Over half belong to other voluntary organizations (Hausknecht, 1962). Thus, between visits with relatives and friends and participation in church and other voluntary organizations, the majority of old people are far from socially isolated.

(18) Older workers have fewer accidents than younger workers. Most studies agree this is true. For example, a study of 18,000 workers in manufacturing plants found that workers beyond age 65 have about one-half the rate of nondisabling injuries as those under 65, and older workers have substantially lower rates of disabling injuries (Kossoris, 1948).

(19) Only 10.3% of the population were age 65 or over in 1975 and this will probably not increase to more than 12% by the year 2000, even if completed fertility drops to zero population growth levels (Current Population Survey, 1975).

(20) Most medical practitioners tend to give low priority to the aged. A series of 12 empirical studies all found that most medical students and doctors, nursing students and nurses, occupational therapy students, psychiatry clinic personnel, and social workers tend to believe the negative stereotypes about the aged and prefer to work with children or younger adults rather than with the aged. Few specialize, or are interested in specializing, in geriatrics (Brown, 1967; Campbell, 1971; Coe, 1967; Cyrus-Lutz & Gaitz, 1972; Delora & Moses, 1969; Gale & Livesley, 1974; Garfinkel, 1975; Gunter, 1971; Miller, Lowenstein, & Winston, 1976; Mills, 1972; Spence & Feigenbaum, 1968).

(21) The majority of persons 65 or over have incomes well above the poverty level. In 1975 there were only 15.3% of the aged below the official poverty level (about $2,400 for an aged individual or $3,000 for an aged couple). Even if the "near poor" are included, the total in or near poverty is only 25.4% (Brotman, 1976).

(22) Over three-fourths of old people are working and would like to have some kind of work to do (including housework and volunteer work). There are about 12% of persons 65 or over who are employed, 21% who are retired but say they would like to be employed, 17% who work as housewives, 19% who are not employed but do volunteer work, and another 9% who are not employed and not doing volunteer work but would like to do volunteer work (Harris, 1975). These percentages total to 78%.

(23) Older people to not tend to becomre more religious as they age. While it is true that the present generation of older persons tend to be more religious than the younger generations, this appears to be a generational difference (rather than an aging effect) due to the older persons' more religious upbringing. In other words, the present older generation has been more religious all their lives rather than become more religious as they aged. Longitudinal studies have found no increase in the average religious interest, religious satisfaction, nor religious activities among older people as they age (Blazer & Palmore, 1976).

(24) The majority of older people are seldom irritated or angry. The Kansas City Study found that over one-half the aged said they are never or hardly ever irritated and this proportion increases to two-thirds at age 80 or over. About three-fourths said they are never or hardly ever angry (Dean, 1962). The Duke Adaptation Study found that 90% of persons over age 65 said they were never angry during the past week.

(25) The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be much higher than now. Measures of health, income, occupation, and education among older people are all rising in comparison to those of younger people. By the year 2000, the gaps between older and younger persons in these dimensions will probably be substantially less (Palmore, 1976).

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APPENDIX B

ANNOTATED BIBLIOGRAPHY

Appendix B reprinted from: *Counseling the Aged.* American Personnel and Guidance Association, Washington, D.C. 1979.
By permission of American Personnel and Guidance Association.

The compilation of the Annotated Bibliography is an ongoing process. The materials provided here illustrate the content classifications and the proposed format which will be followed. Some completed entries are provided under each major heading for format evaluation. Please allow to missing prices, zip codes, page listing and minor format inconsistencies while critiquing for general content, subject-categories, and format. If specific resources come to mind that you feel should be included, please note them as completed as you can immediately recall.

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General Resources	1
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Resources

Center for the Study of Aging and Human Development, Duke University. *Training Resources in Aging 5th Edition.* A microfiche bibliography of films, training manuals, audiovisual resources, course outlines, seminar materials, teacher guides for disciplines such as exercise, nutrition, funding, safety, sanitation, and includes information and referral services. Available from the Center, Duke University, Box 3003, Durham, NC 27710. $1.00.

Clearinghouse on Employment for the Aging. *Employment Resources for the Middle-Aged and Retired: A National Directory.* Information on federal programs and legislation related to employment of older workers, listing of public and private agencies by state, suggested readings, and regional addresses for ACTION (volunteer programs for senior citizens) offices. $3.00.

Institute of Gerontology, The University of Michigan--Wayne State. *A Set of Two Selected Annotated Bibliographies.* By Shirley Harrison, 1976. WORKING WITH THE AGED includes materials relevant to milieu therapy concepts as developed at the Institute and DAY CARE FOR THE ELDERLY includes unpublished and published articles on a variety of day services to the elderly. 520 E. Liberty, Ann Arbor, MI 48109. $1.00.

Institute of Gerontology, The University of Michigan. *Humanistic Perspectives on Aging.* Walter, Moss, Principal Editor. An annotated listing of novels, short stories, dramas, essays and films speaking to human aging and society's attitudes toward it. Resources in Aging Series. 76 pages. 520 East Liberty, Ann Arbor, MI 48109. $3.50.

Institute of Gerontology, The University of Michigan. *Past Sixty: The Older Woman in Print and Film.* By Carol Hollenshead. An annotated bibliography including both scholarly and popular materials. It reflects the social-psychological as well as legal issues and economic issues facing the older woman. Other subjects included are marriage and the extended family, ethnic background, widowhood, health, and sexuality. Resources in Aging Series. 52 pages. 520 East Liberty, Ann Arbor, MI 48109. $3.00.

Institute of Gerontology, The University of Michigan--Wayne State. *Resources in Aging: To Live with Dignity.* Marie-France Boudreault, Vivien Larue, and Lena Metzelaar. A paper describing a Milieu Therapy project planned to meet the needs of the ill and frail elderly. The project offers guidelines for others who work with elderly persons who are often considered untreatable. 60 pages. 520 East Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The University of Michigan--Wayne State.

Staff Development in Geriatric Institutions. Mark B. Kinney. A "how-to" manual for individuals who are training staff of agencies providing care for elderly persons. The focus is on the processes used in fabricating learning experiences, rather than on a collection of exercises to be used in training. 72 pages. 520 East Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The Unviersity of Michigan--Wayne State University. *Day Care for the Elderly: A Selected Annotated Bibliography.* Shirley Harrison. 520 East Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The Unviersity of Michigan--Wayne State University. *Sexuality in the Later Years of Life.* Alida G. Silverman, Annotated Bibliography, 520 E. Liberty, Ann Arbor, MI 48109.

Institute of Gerontology, The University of Michigan--Wayne State University. *Working with the Aged: A Selected Annotated Bibliography.* Shirley Harrison, 520 E. Liberty, Ann Arbor, MI 48109.

National Council on Aging. *NCOA Publications List.* An annotated bibliography of new aging materials. Published biannually. Available from NCOA, 1828 L St., N.W., Washington, D.C. 20036. Free.

National Council on Aging. *A General Bibliography on Aging.* Annotated. 52 pages. 1972. NCOA, 1828 L St., N.W., Washington, D.C. 20036. $4.00. #7213.

National Council on Aging. *The Aged in Minority Groups.* 19 pages. Annotated. 1973. NCOA, 1828 L St., N.W., Washington, D.C. 20036. $2.00. #7315.

National Council on Aging. *Housing and Living Arrangements for Older People.* Annotated bibliography. 14 pages. 1972. NCOA, 1828 L St., N.W., Washington, D.C. 20036. $2.00. #7214.

National Council on Aging. *Retirement Income.* Annotated bibliography. 1972. 10 pages. NCOA, 1828 L St., N.W., Washington, D.C. 20036. $2.00. #7217.

National Institute of Mental Health. *Depression, Grief and Suicide in the Aged, Aging and Mental Health, Sex and Marriage in the Aging, Recreation for the Aging,* and other bibliographies. By Edith Sutherland. 1976. National Clearinghouse for Mental Health Information, 5600 Fishers Lane, Rockville, Maryland 20852. Free.

New England Gerontology Center. *Publications and Periodicals.* An annotated list of aging related bibliographies, audiovisual productions, books, and periodicals. New England Gerontology Center, 15 Garrison Avenue, Durham, New Hampshire 03824. Free.

New England Gerontology Center. *Psychology of Aging.* A general bibliography on such topics as sexuality, death, age-related changes, maladjustment and general psychology theory related to aging. Entries include books, journal articles, periodicals and papers, some of which are annotated. 5 pages. 1977. NEGC, 15 Garrison Ave., Durham, New Hampshire 03824. $1.50. #033.

New England Gerontology Center. *Gerontological Resource Directory of Services and Education Programs in New England.* The directory lists gerontological resources in educational institutions and service programs for older people. Its purpose is to locate resources for service providers, students, and others interested either in the study of aging or the delivery of services to elders. 40 pages. 1977. NEGC, 15 Garrison Ave., Durham, NH 03824. $3.50. #026.

New England Gerontology Center. *Literature and Aging.* A bibliography which focuses on aspects of aging in fiction, non-fiction, drama, and poetry. Recommended for the elderly themselves, educators, trainers, program and project staff for elderly services. 20 pages. 1977. NEGC, 15 Garrison Ave., Durham, NH 03824. $2.00. #038.

New England Gerontology Center. Retirement Bibliography: A compilation of resources on the subjects of RETIREMENT and PRE-RETIREMENT PLANNING. Resources include books, pamphlets, periodicals, and government publications on a range of topics related to retirement such as pre-retirement programs, career changes, retirement experiences, retirement income and alternatives. 15 pages. 1976. NEGC, 15 Garrison Ave., Durham, NH 03824. $1.50. $029.

U.S. Department of HEW. *More Words on Aging.* Supplement to the earlier publication *Words on Aging.* An annotated bibliography of selected references compiled for the Administration on Aging by the Department Library. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.D. 20402. $0.75. Stock No. 1762-0040.

U.S. Department of HEW. *Older Americans Act of 1965 As Amended.* March 1976. DHEW Publication No. (OHD) 76-20170, Dept. of HEW, Office of Human Development, Administration on Aging. For sale by the Superintendent of Documents, USGPO, Washington, D.C. 20402. $1.45.

Information Pamphlets

"Are You Planning on Living...the rest of your life?" Superintendent of Documents, USGPO, Washington, D.C. 20402. Stock No. 017-062-0038-7.

Based on the premise that good retirement requires good planning, this booklet is a "do-it-yourself" planner that can be used at home and is

designed to be used with one other person, e.g., spouse, friend or counselor. The booklet covers financial, leisure, and housing planning and includes a form for contacting the Social Security Administration.

"The Fitness Challenge...in the later years: An Exercise Program for Older Americans." Superintendent of Documents, USGPO, Washington, D.C. 20402. Stock No. 017-062-00009-3.

Prepared by the President's Council on Physical Fitness and Sports and the Administration, this pamphlet outlines three exercise programs graded according to difficulty and designed to help the elderly take advantage of their later years as active years. Simple tests to access one's present level of exercise tolerance and supplementary notes on adults' physical fitness are included.

"Facts and Myths About Aging"

"Fact Book on Aging"

"Your Retirement Consumer Guide"

"Your Retirement Legal Guide"

"Your Retirement Psychology Guide"

"Your Retirement Health Guide"

"Your Retirement Money Guide"

"Your Retirement Income Tax"

"Your Retirement Anti-Crime Guide"

"Your Retirement Hobby Guide"

"Your Retirement Widowhood Guide"

"Your Retirement Home Repair Guide"

"Your Retirement Safety Guide"

"Your Retirement Pet Guide"

"Your Retirement Housing Guide"

"Your Retirement Information Guide"

"Senior Citizens Book of Good Health"

"Save Energy: Save Money"

"The Consumer Information Catalog"

"A List of Guidebooks for Handicapped Travelers"

"Handle Yourself with Care: Accident Prevention for Older Americans"

"On Being Alone"

"Advocacy in the Field of Aging"

"Legal Services for the Elderly"

"Cases and Materials on Medicare"

"Cases and Materials on Social Security"

"Materials on the Rights of the Elderly"

"Tax Benefits for Older Americans"

"Your Medicare Handbook"

"Medicaid, Medicare Which is Which?"

"Facts about Hearing and Hearing Aids"

"Grief Intervention and the Helping Professional"

"Independent Living for the Handicapped and the Elderly"

"Senior Power: A Political Action Handbook for Senior Citizens"

"Pointers for the Veteran Homeowner"

"Summary of Benefits for Veterans with Military Service Before February 1, 1955, and Their Dependents"

"Cooking for Two"

"Food Guide for Older Adults"

"The Food Stamp Program"

"Tax Facts, 1977, for Older Americans"

"The Law and Aging Manual"

"You, the Law, and Retirement"

"Let's End Isolation"

"Your Right to Question the Decision on Your Hospital Insurance Claim"

"Your Right to Question Your Medical Insurance Payment"

"How to Complete the Request for Medicare Payment"

"Home Health Care under Medicare"

"Medicare Coverage in a Skilled Nursing Facility"

"If You Become Disabled"

"How to Choose a Nursing Home"

"Nursing Home Care"

"You can work and still get social security checks"

"Your Social Security Rights and Responsibilities"

"A Woman's Guide to Social Security"

"How SSI can Help"

"Estimating your Social Security Check"

"Social Security and Your Right to Representation"

"Increase in the Social Security Earnings Base"

"Social Security Benefits - Including MEDICARE"

"Social Service Definitions for Title VII of the Older Americans Act"

"Guidelines for a Telephone Reassurance Service"

Sources of Funding Information

A National Guide to Government and Foundation Funding Sources in the Field of Aging, Lilly Cohen and Marie Oppedisan-Reich, Eds. The Adelphi University Press, Adelphi University, Garden City, New York 11540.

A 175-page reference for planners and fund seekers in aging. Comprehensive information on over 85 federal fundings programs by category; federal, regional, and local contacts are included. A description of 125 national, regional and local foundations and a record

of 500 grants awarded in aging from 1972 to 1976 is presented.

Catalog of Federal Domestic Assistance, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. $17.00.

The CFDA is the basic tool for researching sources of federal grant assistance. This 1,000-page plus document provides a complete listing of government programs and is cross-references in a number of ways. Includes information on who is eligible, how to apply, and application deadlines.

The Federal Register, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. $50 a year.

The Register tells what research is being funded this year. All proposed rules, regulations and advisory meetings must appear in the Register. It is published daily and indexed monthly. A subscription includes Code of Federal Regulations.

United States Government Manual.

The Foundation Directory.

The Foundation News.

The Grantsmanship Center News.

The Foundation Grants Index.

Preparing Instructional Objectives.

Fund Development and Technical Assistance Biweekly Newsletter.

Periodicals Pertinent to Older Persons

Active Times. Published by the Society for Pre-retirement Program Planners. Quarterly. Year subscription $7.50. Society for Pre-retirement Program Planners, 2040 North 50th Ave., Omaha, NE 68104.

The publication is directed toward program planners, counselors, directors of programs and students in the field of preretirement planning and aging. Pertinent articles, model counseling programs and resource leads are included.

Current Literature on Aging. National Council on Aging. Quarterly. Subscription with NCOA membership or $5.00 for one year, $9.00 for two years, single copy $2.00. NCOA, 1828 L St., N.W., Washington, D.C. 20036.

Prepared by the NCOA library staff, this publications lists selected recent books and articles under subject headings (aged and aging, community organizations, education, employment, health, housing, institutional care, legislation, nursing homes, retirement, social welfare, etc.).

Adult Leadership

Aging

Aging and Human Development

American Journal of Sociology

American Sociological Review

Community Mental Health Journal

Counseling Psychology

Dynamic Maturity

Geriatrics

Gerontologist

Harvest Years

Human Development

Impact

Industrial Gerontology

Journal of American Geriatrics Society

Journal of Counseling Psychologist

Journal of Gerontology

Journal of Health and Human Behavior

Journal of Human Relations

Journal of Marriage and the Family

Journal of Personality and Social Psychology

Journal of Rehabilitation

Journal of Social Issues

Journal of Thanatology

MEMO Newsletter

Mental Hygiene

Modern Maturity

Omega

Personnel and Guidance Journal

Perspective on Aging

Rehabilitation Counseling Bulletin

Rehabilitation Literature

Retired Officer

Retirement Life

Social and Rehabilitation Record

Social Casework

Social Forces

Social Work

Suicide

Vocational Guidance Quarterly

Audiovisual Resources

Media on Aging: Bibliography. Pam Tilton-Alberts, Ed. A bibliography of over 850 titles of films, slides, tapes, filmstrips, video tapes and plays dealing with gerontology. Nursing homes, retirement, transportation, health, services and programs are included in the topics covered. The catalog annotates the entries and gives technical information about the film and how it can be obtained. New England Gerontology Center, 15 Garrison Avenue, Durham, New Hampshire 03824. #042. $6.50.

KWIC's Film Forum Series. Quarterly updated evaluations of films on aging. KWIC Project, Center for the Study of Aging, Box 3003, Duke

Medical Center, Durham, NC 27710. $1.50 per issue.

Print and Audiovisual Resources. Institute of Gerontology, The University of Michigan--Wayne State. Annotated pamphlet of resources. 520 E. Liberty St., Ann Arbor, MI 48109.

Media Resources in Gerontology. Institute of Gerontology, The University of Michigan. Penelope Sahara. A complete manual of annotated listings of films, slides, videotapes and audio tapes. Addresses of distributors included. 520 E. Liberty, Ann Arbor, MI 48109. 144 pages.

Sources of Information and Help -- Some Useful Addresses

The following national organizations provide technical assistance, information and referral, policy advocacy, conduct research, and in some cases provide training in their area of concern.

AMERICAN ASSOCIATION OF HOMES FOR THE AGING. 1050 17th Street, N.W., Washington, D.C. 20036. The professional association organization of non-profit community-sponsored housing projects, homes for the aging and health-related facilities serving the elderly throughout the United States working to promote the professional skills and sensitivities of its members and offer interaction with congressional and federal agencies in developing policies conducive to the total welfare of older Americans.

NATIONAL ASSOCIATION FOR SPANISH-SPEAKING ELDERLY. 1801 K Street, N.W., Suite 1021, Washington, D.C. 20006 or 3875 Wilshire Blvd., Suite 401, Los Angeles, CA 90005. Older persons mass membership and professional association dedicated to articulating the social service needs of the Hispanic Senior Citizens.

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING. 1828 L Street, N.W., Suite 505, Washington, D.C. 20036. A nonprofit corporation serving as the central national resource for Area Agencies on Aging.

NATIONAL ASSOCIATION OF COUNTIES and NATIONAL ASSOCIATION OF COUNTIES RESEARCH FOUNDATION. 1735 New York Ave., N.W., Washington, D.C. 20006. An affiliate of local government representing the interests of county government at the national level, a top priority being a strong commitment in federal dollars to assure availability of services to older citizens.

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES. 8230 Forsyth, St. Louis, MO 63105. Represents home health and related agencies at the national level on home health care issues.

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES. 1533 New Hampshire

Ave., N.W., Washington, D.C. 20036. Older persons mass membership organization, restricted to those covered by Federal Civil Service, their spouses and survivors, representing the legislative interests of retirees from the federal government.

NATIONAL ASSOCIATION OF STATE UNITS ON AGING. 1828 L Street, N.W., Suite 505, Washington, D.C. 20036. The professional association of State Units on Aging allowing them to act collectively and permitting informed and considered action between the States as a positive force to improve the status of older persons.

NATIONAL CENTER ON BLACK AGED. 1730 M Street, N.W., Washington, D.C. 20036. Offers consultation services to local and national aging organizations, is dedicated to developing a cadre of Black professionals in the field of gerontology, and encourages the development of leadership roles on the part of Blacks, low-income and other minorities in planning and delivery of social services.

NATIONAL COUNCIL ON AGING. 1828 L Street, N.W., Washington, D.C. 20036. Professional association and affiliation of organizations and individuals concerned about aging providing leadership and guidance in the development of services for the elderly and improving the quality of life for older persons.

NATIONAL COUNCIL OF SENIOR CITIZENS. 1511 K Street, N.W., Washington, D.C. 20005. Older persons' mass membership organization which promotes the interests of senior citizens by engaging in fact-finding analyses of issues, and by providing a responsive and articulate voice for the senior citizens to promote their general welfare.

NATIONAL INDIAN COUNCIL ON AGING, INC. P.O. Box 2088, Albuquerque, New Mexico 87103. An organization providing advocacy for the Indian and Alaska Native elderly, specifically to bring about the remedial action recommended at the National Indian Conference on Aging.

NATIONAL SENIOR CITIZENS LAW CENTER. 1709 West 8th Street, Los Angeles, CA 90017. A legal services support center providing assistance to legal service attorneys in local programs offering legal assistance to the elderly poor. Assists 29 states in developing legal services for the elderly under Title III of the Older Americans Act.

NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS. 1909 K Street, N.W., Washington, D.C. 20049. Older persons' mass membership organizations providing services and information to enhance enjoyment of life for retired persons and to benefit the community.

URBAN ELDERLY COALITION. 1828 L Street, N.W., Washington, D.C. 20036. Affiliation of public agencies/ officials or private agencies which represent a city to be an advocate in behalf of the urban elderly.

The Coalition provides ongoing education of leaders and staff of urban area offices on aging.

ADMINISTRATION ON AGING. U.S. Department of Health, Education and Welfare, Office of Human Development, North Building, Washington, D.C. 20201. Clearinghouse on Aging provides information on services for the elderly in specific areas.

AREA AGENCIES ON AGING.

STATE AGENCIES ON AGING.

CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING. Division of Special Mental Health Programs, National Institute of Mental Health, 5600 Fishers Lane-Room 18-95, Rockville, MD 20852. Centralizes NIMH's efforts on behalf of the mental health of the aging by coordinating NIMH Divisions with support programs for research, training, and services, analyzing NIMH research, training, and service programs and recommending the extent to which such mechanicms should be developed.

ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION. One Dupont Circle, Suite 520, Washington, D.C. 20036. A professional organization of educational institutions which provide research, professional and other related training and education for gerontology, and to provide a network of communication among such institutions.

GERONTOLOGICAL SOCIETY. One Dupont Circle, Suite 520, Washington, D.C. 20036. Professional association dedicated to promoting the scientific study of aging in the biological and social sciences, stimulating communication between researchers, teachers, professional and others and to broadening education in aging.

INTERNATIONAL CENTER FOR SOCIAL GERONTOLOGY. 425 13th St., N.W., Suite 350, Washington, D.C. 20004. A nonprofit research center to advance the social welfare of older people by encouraging and conducting research in various aspects of social gerontology; disseminating information on an international basis; and stimulating the development of training programs to prepare professional workers in the field of aging.

NATIONAL CONFERENCE OF STATE LEGISLATURES. 444 North Capitol St., N.W., Washington, D.C. 20001. Affiliation of public agencies and officials to improve the effectiveness and quality of state legislatures and to assure states a strong, cohesive voice in the federal decision-making process.

NATIONAL GOVERNORS' CONFERENCE. 444 North Capitol Street, Washington, D.C. 20001. Affiliation of public agencies and officials to represent

the interests of state government at the national level.

U.S. CONFERENCE OF MAYORS. 1620 Eye Street, N.W., Washington, D.C. 20006. Affiliation of public officials to promote the interests of big cities; to enhance municipal program development; and to disseminate information.

WESTERN GERONTOLOGICAL SOCIETY. 785 Market Street, Rm. 616, San Francisco, CA 94103. Regional organization on aging dedicated to improving the quality of life of older persons through training, education, communication, and advocacy with older persons themselves and those serving older persons.

SELECT COMMITTEE ON AGING, U.S. HOUSE OF REPRESENTATIVES. Claude Pepper, Chairman, Room 712, HOB Annex 1, 300 New Jersey Ave., S.E., Washington, D.C. 20515. Subcommittees: Retirement Income and Employment, Health and Long-Term Care, Housing and Consumer Interests, Federal, State, and Community Services.

SELECT COMMITTEE ON AGING, U.S. SENATE. Frank Church, Chairman.

NATIONAL INSTITUTE ON AGING. National Institutes of Health.

Books

Aging and the Aged. Fred Cottrell. Wm. C. Brown Co., Iowa, 1974.

This short book was intended for persons wanting to learn about aging from a sociological point of view. It succinctly covers the processes of aging: health, income, employment, retirement, social, political, friends, family, neighbors and religion.

Aging and Mental Health: Positive Psychosocial Approaches. Robert N. Butler and Myrna I. Lewis, St. Louis, MO: Mosby, 1973.

This text is written about the struggle for quality mental health care of the elderly. Of particular interest to counselors are chapters 9, 10 and 12 dealing with evaluation, keeping the individual at home, and psychotherapy respectively.

Sexuality and Aging. Irene Burnside.

Mental Illness in Later Life. Ewald Busse and Eric Pfeiffer.

Why Survive? Being Older in America. Robert N. Butler.

Sex After Sixty. Robert N. Butler and Myrna I. Lewis

The Coming of Age. Simone de Beauvoir.

The Psychology of Adult Development and Aging. Carl Eisdorfer and M. Powell Lawton.

Sex in Later Life. Ivor Felstein.

The Psychological Aspects of the Aging Process: With Sociological Implications. Warren H. Green.

The Later Years: Social Applications of Gerontology. Richard A. Kalish.

Middle Age and Aging: A Reader in Social Psychology. Bernice L. Neugarten.

Model Programs

Two Years with Eight Patients: The Evolution of a Therapeutic Environment. Vivien LaRue. Institute of Gerontology, University of Michigan, 520 E. Liberty St., Ann Arbor, MI 48109. 1973, 39 pages, $1.95.

The author describes a 24-month transformation of a therapeutic program involving older patients in a goal-oriented activity milieu.

"On Widowhood: A Discussion," David Blau, *Journal of Geriatric Psychiatry,* 8(1): 29-440, 1975.

A mutual help program for elderly widows is described in which widow helpers who had adapted well to their own bereavement were utilized.

Social Interaction Groups in a Therapeutic Community.

Programs for the Elderly.

Mental Hospital Programs.

Research and Demonstration Projects in Medical Care Facilities.

Challenging Residents to Assure Maximal Responsibilities in Homes for the Aged.

Treatment of Depression in Persons Residing in Homes for the Aged.

The Development of a Community-Based Program for Evaluating the Impaired Older Adult.

Protecting the Vulnerable Adult.

Effective Social Services for Older Americans.

Catawba Hospital Handbook for Facilitators.

A Therapeutic Milieu for Geriatric Patients.

A Way of Examining Practices in a Treatment Setting

Activities in a Treatment Setting.

COORDINATOR'S GUIDE

COUNSELING NEEDS OF THE OLDER ADULT

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ROLE OF COORDINATOR

Your role as a leader and motivator is critical for the success of this module. The following guidelines are offered to assist you.

Set the Tone

Physical - In this module comfortable seating arrangements are a *must* when working with older adults. Avoid, if possible, "traditional" classroom chairs. Make sure adequate restroom facilities are close by. The physical site should be within comfortable walking range from the parking facility.

Personal - The mood or attitude you project at the beginning of the workshop gives the participants an indication of the day's activities. Because this module deals with negative items such as stereotypes and biases, it is important that you, as the coordinator, set a climate for open, free discussion of the misinformation some participants have about older adults. Although motivation and interest are key points for the workshop's progress, you need to clarify how important it is to follow the directions given in each module so that the specific outcomes can be accomplished.

Set the Pace

Some activities will require a different pace to be set. Be in rhythm with your audience as well as the materials. If things seem to be too slow, increase the pace. Feel free to summarize sections orally, if time is running short. Allow for humor and discussion; it will assist in personalizing the material and keeps interest high. It is important to have the participants involved in all the activities, but be flexible with your break times.

Facilitate

Lots of energy can be generated from group interaction. As the coordinator you can facilitate the discussion, but also maintain

direction, so the sharing doesn't dominate the progress. Be very sensitive to the "signals" your audience sends you and try to spot trouble before it interferes with the presentation. Your role is to guide the group and keep the transitions from one activity to the next smooth and fluid.

Evaluate

Everyone will benefit from achieving the outcomes of the module. You are the person who assists the group in completing the evaluation activities. Participate yourself, to demonstrate and encourage group members to strive for quality and success in each activity area.

MODULE OUTLINE

SUGGESTED TIME SCHEDULE

Approximate Time	Activity	Objectives
Half hour	Beginning Actities Ice-breaker activity Module coordinator administers pre-test	
1 hour	Introduction and Text Activity Module coordinator conducts Introductory Activity. Provide text and discussion activity for Objective 1.	1
1 hour	Text Activity Text activities related to critical issues facing the older adult and criteria which influence one's accommodation to change.	2
1 1/2 hours	Skill Activity Activities designed to identify one strengh and one weakness in attending and listening skills.	3
1 1/2 hours	Application of Skill Activity Activities involving a systematic problem strategy to help older adults solve problems.	4
Half hour	Concluding Activity Discuss results of pre-test.	

FUNCTIONS OF COORDINATOR

Pre-Workshop Role

1. Study the module thoroughly ahead of time. Be comfortable with all materials in both the participant and Coordinator's Guide.

2. Have yourself organized, so that you can enjoy the workshop! Check ahead of time for chalkboard, chalk, paper, pencils, name tags, and 3x5 index cards (always plan to include 10 more than what you think you need!)

3. Check your materials ahead of time! You can save time, organizing your activity sheets according to the sequence of presentation. Save all the time you have with the participants to work with them! If you want the participants to leave with their module material intact, you must furnish extra activity sheets to utilize during the workshop.

4. *Environment.* A pleasant room environment certainly helps the success of the workshop. Tables are very important because of the writing involved. The instruction of the module has been structured around subgroups of four. Inaugurating this arrangement as participants will facilitate workshop proceedings.

At the Workshop

1. Introduce yourself to participants and set a quick, relaxed mood for the "Ice-Breaker" activity (see Ice-breaker). Briefly communicate to the group what your role as coordinator will be.

2. Acquaint the participants with the time schedule and the flexible arrangements possible for breaks.

3. Some parts of the text are lengthy. Avoid reading to the participants directly from your copy. Be familiar with the material ahead of time so that you can key-note the high points and give examples to clarify the material. The text is informative, but examples and group discussion can serve as a motivator as well.

4. Conduct a summary exercise at the end of each section and at the end of the workshop. Your tasks include:

a. Summarize what has been accomplished and its relationship to the module.

b. Resolve any unanswered questions.

c. Suggest additional resources and/or review of the Appendix section for further information.

5. Module Improvement - Each group could offer suggestions or express need for workshop improvement. Keep involved with the progress of the module and collect recommendations for ways to improve the workshop materials. Write these down! Your recording can help you change and/or adapt these materials for the next time around.

SPECIFIC SUGGESTIONS FOR EACH SECTION

Ice-Breaker and Test

A. Ice-Breaker - You, as coordinator, may select your best get-acquainted technique. The purpose of this exercise is to allow the group to become acquainted and set the "tone" for the first activity. If you haven't an "ice-breaker" technique in mind, the following is suggested.

Hand out 3x5 index cards. Instruct group to write the name they prefer being called by in the center of the card and at least three really *good, positive* things they have in their life (this could include roles, activities, job, etc.). Encourage them to mingle, read each other's card until they have made contact with the entire group. (The coordinator could watch the clock and every minute instruct the people to change partners!)

B. Administer the Test - It is critical that the test "Facts on Aging" be administered in a neutral, unbiased manner. Oftentimes people will answer a quiz such as this one, the way they think they "should" or the way they feel things "ought" to be. The emphasis of this workshop will be on the participants examining their own biases and assumptions regarding the older student. The climate you set for the activities is vital to the success of the module.

You could explain that the quiz will be discussed at the end of the workshop. It will be interesting to discover if attitudes change after the workshop experience. Their answers will be discussed in the last workshop activity. Assure them that they will not have to share their answers if they do not choose to do so.

If your training audience is primarily older adults (65 years and older), plan to divide the activities into two half-day sessions. Usually a 9:00 to 11:30 schedule is most comfortable for these participants. The length of sitting time and depth of attention span required to complete this module can put undue physical stress on the older adult. The two half-day sessions allow for the rest and comfort needs of the audience.

Utilizing Subgroups

Subgroups are utilized as part of the process of teaching this module. Subgroups of four participants seem most appropriate for several reasons. Two pairs can emerge for certain types of activities, and in other activities, two members of the subgroup can serve as judges in rating the performance in role-play of the other two members. Also, individual activities can become group activities and speed up the process if certain time limits need to be met.

Retaining the same subgroup of four throughout the workshop is advantageous because the members feel more at ease with each other, and the feeling enhances the exchange of remarks needed in the skill activities. The division of the total group into the subgroups needs to come near the beginning. Participants' cards for the ice-breaker activities might be numbered or the group may count off, for example, after taking the pre-test. If different age levels, etc., are involved it maybe necessary to structure a system of division which can insure a true cross-section of the total group into each of the subgroups.

INTRODUCTORY ACTIVITY

Materials

* One large sheet of paper or chalkboard
* Tape
* Felt pen or chalk
* 3x5 index cards

Instructions

You, as coordinator, can point out that the purpose of this activity is to give the participants an opportunity to express their feelings about maturing. Use a duplicated copy of this Introductory Activity if you want to keep the module intact.

Procedure

Allow the group five minutes to write down adjectives. On a large sheet of paper (or chalkboard), use the following outline.

	Physical Health	Mental Health	Finances	Family	Interests	Personality
65-70						
70-75						
75-80						

Allow for group participation. Encourage all members to offer at least one adjective in two categories.

Examine, with group participation, the differences, if any, in the adjectives selected to describe adults as they grow older. Discussion could be stimulated by asking the following questions:

What influence did their perception of aging have with their choice of adjectives?

Were their responses influenced by the "image" of aging (or the myths and stereotypes about aging)?

SECTION ONE - THE OLDER ADULT--BIASES AND STEREOTYPES (OBJECTIVE ONE)

Objective One: Identify and describe in writing: (1) at least one bias, stereotype, or attitude about the elderly which you personally hold and the possible effects of that bias in your counseling of the elderly; (2) at least one attitude you have regarding the elderly and the possible client benefits to be derived from it.

Instructions

Do not read to the group the section on Butler's description of the negative biases and stereotypes of aging. Instead, discuss and highlight the major points. Emphasize that negative biases and assumptions can influence our perception of the older adult.

How does the Introductory Activity summed up above relate to the sections described by Butler: (1) physical/mental health, (2) finances, (3) relationships with family and friends, (4) interests and activities, (5) personality traits.

Procedures

Utilize the subgroups of four. Each member will select a different section, i.e. Physical Health.

Allow adequate time for reading and notetaking.

Instruct each member to briefly highlight the information provided in his/her reading to other members of the subgroup.

Recap with the total group the concern that people who are working with older adults need updated information.

Go over the instructions for Activity One, Meeting the Requirements for Objective One.

Once the participants have finished the two paragraphs, have them exchange papers with a member of their subgroup and complete the checklist.

Collect the checklists for personal evaluation and of the success of the activity.

SECTION TWO - CONCERNS FOR CHANGE AND ADJUSTMENT OF THE OLDER ADULT (OBJECTIVE TWO)

Objective Two: Describe examples of older adults' positive and negative accommodation to change and life role status and state examples of factors that explain each type of accommodation.

Note: Try to establish a relationship or transition with the activities as they are presented, for example: Review briefly that Section One reminded us that external factors definitely play a significant role in determining "successful" aging. We can perceive life as a circular process. A process where the beginning, as well as the ending, have equal wealth and significance.

Instructions

Coordinator "highlights" the material provided for participants in the text section of Section Two. Avoid reading directly from the text to the group.

Additional data to motivate group attention could include:

Financial factors - in 1971, the White House Conference on Aging conducted a survey of nearly 200,000 persons 65 and older and asked them how they felt about their finances. Over half of these people received and spent less than $200 a month; over one-third had trouble paying their housing costs; over half stated they did not always have money to "make ends meet."

Social-cultural factors - Factors to highlight could be change in family routine, society's attitude about aging (value of age) and the development of new roles. "You married me for dinner, but not for lunch." This quote focuses on the readjustment of family and marriage roles that are common in the retirement period.

Kalish (1975) offers four possible definitions of successful aging:

(1) A way of life that is socially desirable for this age group.

(2) Maintenance of middle life activities.

(3) A feeling of satisfaction with one's present status and activities.

(4) A feeling of happiness with one's life.

Adapting to Change - In many situations, the person's mode of adapting to old age is a direct outgrowth of a long-term adjustment pattern. Although the older person may disengage from previous role-activities, they are not likely to disengage from the social values they have internalized over the years. The continuous adjustment between life roles and values is the pivotal concern of the individual's accommodation of aging.

Procedure

Coordinator motivates discussion with group members and keeps the pace of the activity "lively."

Provides an extra activity sheet for evaluation. Have the participants write their paragraphs on the back of the sheet or on other paper.

Collects the completed checklists for personal evaluation.

SECTION THREE - EFFECTIVE ATTENDING AND LISTENING SKILLS (OBJECTIVE THREE)

Objective Three: Identify strengths and weaknesses in your listening and attending skills.

Try to "re-cap" briefly the progress of the workshop at this point. The purpose of the next activity is to appreciate the importance of good attending and listening skills. Highlight the information provided in the text for Activity Three. Use examples and personal experiences that could personalize the information and set the rhythm for the next activity.

Instructions

Coordinator demonstrates the entire role-playing activity for the group. (1) Select three volunteers from the audience. The coordinator will role-play the speaker in the experience. (2) Explain the roles of the observers, the listener and the speaker. (3) The coordinator

uses the same sheet that all participants have:

When I think of myself as an older adult, I would describe my:

Activities as: (reasonably active)

Personal attitudes to be: (pretty positive)

People in my life: (family and close friends)

(4) Coordinator now uses the information from this sheet to dramatize or role-play that older adult. (5) All the volunteers to "act" out their role as: two observers and one listener. (6) Observers rate the interaction on the sheets provided by coordinator. Audience rates this activity also to practice the process. (7) Coordinator checks with audience to encourage questions about the role playing, roles of listener, observer and speaker. (8) Coordinator gives each participant four rating scales (the participants need one extra sheet to use in the demonstration period).

Procedure

Each participant acts the role of the listener once, and there should be two observer ratings made.

For successful completion, a participant needs from 12-15 points.

The need to circulate will be great, because there will be participants who will be having their first experience with this type of activity. Encourage those with more experience to go first, so that the more reluctant ones can see a pattern emerge.

SECTION FOUR - PROBLEM SOLVING STRATEGIES FOR THE OLDER ADULT (OBJECTIVE FOUR)

Objective Four: Apply a problem solving strategy to help solve problems.

This is the culminating activity. Really pull together the information shared at this point, so you can encourage the group to perceive the older adult as a changing, adapting person. Emphasize the importance of problem solving skills! Not the importance of providing answers, but the skills necessary to provide a framework for the

older adult to work out their concerns. Attempt to communicate that problem solving is a skill you use "with" not "for" someone else!

Highlight the information provided in Section Four. Remind the audience of the special characteristics of older people and relate the case studies to the text material. (For example, what case study could be associated with "Change in Sense of Time.")

1. Role play the following case study as a demonstration prior to large group participation. The coordinator needs to demonstrate very clearly how the group will interact and what the role of client and counselor are.

DEMONSTRATION ACTIVITY

(Coordinator will role play counselor; ask for volunteer from group to be the client.)

Case Study - Marion

Marion is a retired electrician. She was always active in her local union and has been known as one of the forerunners in establishing good labor relation laws. She still goes to the union hall to visit and contributes her time freely to the organization.

Marion has many legal documents, momentoes, awards and pictures of the history and growth of the local union. She began to think about leaving them in a special spot in the union hall for all to remember.

The electricians' union has a special committee that reviews the documents that can be put on display in the hall. Marion feels a little nervous about offering her personal papers and awards, but feels that the history represented through them is too valuable to lose. Her family members have expressed an interest in keeping these awards "in the family." But Marion feels they would be safer in the union hall.

Marion has made an appointment to talk to the coordinator of the committee to present her gift.

2. Coordinator role plays the coordinator (counselor) role. Volunteer role plays the role as Marion.

3. Discuss and highlight the skills and what special characteristics discussed in the text is being demonstrated here.

Procedure

Coordinator gives each participant three separate counselor rating scales to rate each of three members of the subgroup of four.

Keep close attention to the progress of this activity. Remember to get audience to associate role playing activity with functions of that group, such as elder function, creativity, etc. Create an atmosphere of "reality" in this role-playing situation. It is vital that the participants associate the skills necessary to assist in problem solving situations. Sometimes the "skills" are lost in the "drama" of the role playing situation. Allow for quick discussion of the activity after all participants have been through the counselor and the rating blanks have been completed.

Remember that the intended audience is expected to have few counseling skills, but may have good helping skills gained from life experience. Such individuals might be asked to go first to help model for the others in their group.

SUMMARY

The last activity is the scoring of the pre-test and the discussion of the documentation supporting the answers. The key to the correct answers is simple. All the odd-numbered items are false, and the even-numbered are true. Information for this can be found in Appendix A. This discussion can serve as the capstone activity, because the participants can recognize if any changes in attitudes have come about because of the information and skills gained in the workshop.

NATIONAL CONSORTIUM ON COMPETENCY-BASED STAFF DEVELOPMENT

MODULE PERFORMANCE RECORD

MODULE TITLE: _____

WORKSHOP DATES: _____

WORKSHOP COORDINATOR(S): _____

_____

Participants' Names (Alphabetically)	OBJECTIVES (Place a check (✓) mark for each objective achieved.)						
	1	2	3	4	5	6	7
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Developed at the American Institutes for Research, under support by the United States Office of Education, Department of Health, Education, and Welfare.

SAMPLE EVALUATION INSTRUMENTS

On the next five pages are two sample instruments, the Module Performance Record and the Evaluation Questionnaire for Staff Development Workshops. You may wish to use these instruments to gather information for evaluating any workshop in which you administer this module, and for making decisions about future workshops. The Module Performance Record (MPR) is a form for tallying participants' achievement of objectives. The Evaluation Questionnaire seeks participants' opinions on four dimensions: (1) perceived value of the workshop; (2) effects of participating in the workshop; (3) role and performance of the coordinator; and (4) recommended improvements in the workshop. As it now stands, the questionnaire should take participants 10-20 minutes to complete. You, as module coordinator, should complete the MPR form based upon the results of the postassessment or other evidence supplied by participants. If you duplicate the Evaluation Questionnaire for participants to complete, we suggest you print it as a four page booklet.

Revised May 1978

NATIONAL CONSORTIUM ON COMPETENCY-BASED STAFF DEVELOPMENT

EVALUATION QUESTIONNAIRE FOR STAFF DEVELOPMENT WORKSHOPS

Your responses to the brief questions in this booklet will help us evaluate the workshop you just completed and make decisions regarding future workshops. Please take 10-20 minutes to answer honestly and thoughtfully. You need not sign your name, but we do need your help. Please answer each question. Thank you.

Name (Optional) _____ Date _____

Module Title _____

A. General Issues Related to the Workshop

Respond by checking the column (A, B, C, D, or E) of the statement which best expresses your feeling or opinion on each item in the following list. If none of the possible choices precisely represents your view, pick the one that comes closest.

STATEMENTS	Column A: I strongly agree	Column B: I agree	Column C: I disagree	Column D: I strongly disagree	Column E: I don't know. I have no basis for answering.
1. This workshop made a valuable contribution to my professional development.					
2. I acquired no new knowledge during this workshop.					
3. I would not recommend this workshop to anyone else.					
4. I am glad I attended this workshop.					
5. In this workshop, I experienced at least one positive change in my knowledge, attitudes, or skills.					
6. As a result of this workshop, I expect that I will help improve the career guidance program in my work setting.					
7. I experienced at least one negative effect from this workshop.					
8. This module must be improved.					
9. The Coordinator was an asset to this workshop.					
10. The Coordinator was unprepared.					
11. The Coordinator was poorly organized.					
12. The Coordinator was clear and to the point.					
13. The material and activities in this workshop were not helpful.					
14. The material and activities were applicable to my needs.					
15. The material and activities were routine and boring.					
16. The workshop's objectives addressed the training needs that I faced they would.					

Developed by the National Consortium on Competency-Based Staff Development in cooperation with the American Institutes for Research, under support by the United States Office of Education, Department of Health, Education, and Welfare under Part C of the Vocational Education Act of 1963.

B. Please list and briefly describe up to three major positive changes that you have experienced in your knowledge, attitudes, or skills because of this workshop. Continue on the back of this booklet if necessary. If you did not experience any positive changes, please check the appropriate space.

_____ There were no positive changes.

C. Please list and briefly describe any negative effects you have experienced because of this workshop. Continue on the back of this booklet if necessary. If you did not experience any negative effects, please check the appropriate space.

_____ There were no negative effects.

D. Please list and briefly describe any improvements you anticipate in your career guidance program as a result of this workshop. Continue on the back of this booklet if necessary. If you don't expect any improvements as a result of this workshop, please check the appropriate space.

_____ I don't expect any improvements in my career guidance program as a result of this workshop.

E. Please list and briefly describe any other comments on this workshop, criticisms of it, or suggestions you have for improving it. We are especially interested in your ideas on topics or activities that should receive more or less emphasis. Continue on the back of this page if necessary.

NATIONAL CONSORTIUM COMPETENCY-BASED STAFF DEVELOPMENT RESOURCES

Modules 1-12 comprise a series on Developing Comprehensive Career Guidance Programs.

1. Career Development Theory
   Barbara Sanderson and Carolyn Helliwell

2. Program Development Model
   Charles Dayton and H. B. Gelatt

3. Assessing Desired Outcomes
   Charles Dayton

4. Assessing Current Status
   Phyllis DuBois

5. Establishing Program Goals
   Charles Dayton

6. Specifying Student Performance Objectives
   Laurie Harrison

7. Selecting Alternative Program Strategies
   H. B. Gelatt

8. Specifying Process Objectives
   Barbara Pletcher

9. Developing Program Staff
   Barbara Pletcher

10. Trying Out Activities and Monitoring Early Implementation Efforts
    Steven M. Jung

11. Conducting Summative Evaluation (Cost-Impact Studies)
    Jean Wolman

12. Communicating Evaluation Results
    Sarah Roberts

The remaining modules address other competencies necessary for providing comprehensive career guidance.

13. Utilizing Strategies for Adult Guidance
    Zandy Leibowitz and Nancy Schlossberg

14. Designing Programs for Adult Guidance
    Zandy Leibowitz and Nancy Schlossberg

15. Providing Life/Career Planning for Women and Girls
    Janice M. Birk

16. Providing Career Guidance for Young Women
    Pamela G. Colby

17. Enhancing Understanding of Students with Physical Disabilities
Susan L. McBain

18. Helping Students Explore Work and Leisure Options
Pamela G. Colby

19. Planning a Career Resource Center
Robert A. Wood, Neal Rogers, and Clella Klinge

20. Developing People Relationship Competencies for Career Resource Center Technicians
Jill Paddick and Dale Dobson

21. Developing Facility Maintenance Competencies for Career Resource Center Technicians
Clarence Johnson

22. Planning Pre-Employment Programs
Joyce Fielding and Marvin Fielding

23. Conducting Job Development Programs
Joyce Fielding and Marvin Fielding

24. Conducting Job Placement Programs
Joyce Fielding and Marvin Fielding

25. Conducting Follow-Up and Follow-Through Programs
Joyce Fielding and Marvin Fielding

26. Imaging Futuristic Career Guidance Goals
Juliet V. Miller, Garry R. Walz, and Libby Benjamin

27. Imaging Futuristic Career Guidance Programs
Juliet V. Miller, Garry R. Walz, and Libby Benjamin

28. Using Change Agent Skills to Manage Career Guidance Program Development
Juliet V. Miller

29. Using Change Agent Skills to Manage Career Guidance Program Implementation
Juliet V. Miller

30. Developing Effective Public Relations
Norman C. Gysbers

31. Developing and Conducting In-Service Programs
Al Stiller

32. Providing Leisure Information in the Career Resource Center
Ron Klein and Robert Swan

33. Developing Career Center Resources for Faculty Use
Marlene Fredricksen and Robert Swan

34. Providing Career Guidance in a Group Setting
Perry Samuels

35. Personalizing Career Guidance Assessment Information Through Group Counseling
Joe Wittmer and Larry C. Loesch

36. Clarifying and Articulating Individual Values and Skills for Career Planning
Jerald R. Forster

37. Helping Parents to Help Adolescents in Career Exploration
Janice M. Birk

38. Helping Young Adults Make the School-to-Work Transition
Sherri Johnson, C. D. Johnson, and Niel Carey

39. Helping the Community Help Students with Career Development
Richard Lutz and Jim Crook

40. Establishing Community-Based Employment Programs
Ellen A. Stewart

41. Designing Career Development Programs for Business and Industry
Zandy Leibowitz and Nancy Schlossberg

42. Developing Coping Skills for Career-Related Changes
Phil Abrego and Lawrence Brammer

43. Helping People with Preretirement Planning--An Introduction
Garry R. Walz, Libby Benjamin, Helen L. Mamarchev, and Beverly Pritchett

44. Counseling Needs of the Older Adult
Patricia Cook and Ellen Stewart

45. Specializing Career Guidance Strategies for Use with Ethnic Minorities
Woodroe M. Parker and Roderick J. McDavis

46. Using Self Awareness and Effective Communication for Helping Ethnic Minorities with Career Guidance
Roderick J. McDavis and Woodroe M. Parker

47. Helping Elementary School Students Develop Decision-Making Skills
Lee Winocur

48. Consulting in the Area of Career Guidance
Tom Quinn

49. Planning Collaborative Career Guidance Projects
Larry C. Loesch and Joe Wittmer

50. Becoming Resource Resourceful
Garry R. Walz, Libby Benjamin, Helen L. Mamarchev, and Beverly Pritchett

51. Making Change Happen: Learning a Systematic Model for Change
Libby Benjamin and Garry R. Walz

52. Making Change Happen: Overcoming Barriers to Change
Libby Benjamin and Garry R. Walz

The National Consortium has also produced a catalog of competency-based programs and lists of desirable competencies for providing comprehensive career guidance.

53. Competency-Based Education for Guidance and Counseling Personnel: A Catalog of Programs and Competencies--Second Edition
Susan L. McBain, Compiler